22. *Date of Last Physical Examination (mm/dd/yyyy): mm dd ccyy

23. *Route of Administration (and Code)

24. *Anticipated Length of Therapy:

- Select
- Oral
- Topical
- Injection
- Buccal
- Dental
- Inhalation
- Intradermal
- Intramuscular
- Intraperitoneal
- Intravenous
- Irrigation
- Miscellaneous
- Mucous_Membrane
- Nasal
- Ophthalmic
- Otic
- Perfusion
- Rectal
- Sublingual
- Transdermal
- Translingual
- Urethral
- Vaginal
- Other

Part D - Certification of Medical

25. *Has the patient tried and failed to -counter or other prescribed products for the diagnosis provided? I ◯ Yes ◯ No

26. *Are there commercially available iate for the diagnosis? ◯ Yes ◯ No

27. *Are all of the active ingredients o approved for the diagnosis provided? If no, please explain below ◯ Yes ◯ No

Ingredients

28. Complete the following for each a n the compounded drug; IF MORE THAN TEN ACTIVE/INACTIVE INGREDIENTS ARE G NAME, NDC, QUANTITY, STRENGTH, AND MEDICAL NECESSITY FOR EACH) AND EXPLAI TEN IN ITEM NUMBER 30. Only the most cost effective and medically necessary ingredients ements, such as resveratrol, lavender oil, and alpha-lipoic acid, cannot be authorized on this for be returned to the provider. Herbal supplements are authorized only on an exception basis hief Medical Officer or his/her designee.

*Drug Name

*Quantity

*Medically Necessary? ◯ Yes ◯ No