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Program: FECA Org. Name: PROFESSIONAL CASE MGMT SERV. INC Provider ID: 197423900

LMN Form Submission

Instructions - CA 26 LMN Compounded Drugs form

OMB No. 1240-0055
Expires: 10/31/2019
Oct 2016

Please specify which type of LMN request you would like to Enter

(•) Non Opioid Compounded (CA 26 LMN Compounded Drugs)

Authorization Request form and Certification/Letter of Medical Necessity for Compounded Drugs

This form is to be completed and signed by the patient's treating physician for any compounded drug. A compounded drug is a combination of two or more drugs prepared by a pharmacist to meet the patient's individual needs. Complete all sections of this form. Failure to complete this form in its entirety may result in delayed processing or an adverse determination for insufficient information. The form is valid and effective for up to 90 days following the date of the treating physician's signature/certification.

Part A - Patient Information

1. *Last Name: *First Name: Middle Initial:
2. *Patient OWCP #: 3. Street Address:
4. *Date of Birth (mm/dd/yyyy): mm dd yyyy 5. City: 6. State: Select
7. Zip: 8. Phone #:

Part B - Treating Physician Information

9. * Treating Physician Name: 10. *Treating Physician NPI #:
11. *Street Address: 12. *Provider ID#: 197423900
13. *City: 14. *State: Select 15. *Zip:
16. *Phone #: 17. Secure Fax #:

Part C - Compounded Drug Information

18. *Medication Name: 19. *Primary Diagnosis:
20. *ICD-10 Code: 21. *Direction for use (for 90-day period or less):
22. *Date of Last Physical Examination (mm/dd/yyyy): mm dd ccyy
23. *Route of Administration (and Code) Select
24. *Anticipated Length of Therapy: Select

Part D - Certification of Medical Necessity

25. *Has the patient tried and failed to obtain relief through over-the-counter or other prescribed products for the diagnosis provided? If no, explain below in item 30. ○ Yes ○ No
26. *Are there commercially available FDA-approved drugs appropriate for the diagnosis? ○ Yes ○ No
27. *Are all of the active ingredients of the compounded drug FDA-approved for the diagnosis provided? If no, please explain below in item number 30. ○ Yes ○ No

Ingredients

28. Complete the following for each active and inactive ingredient in the compounded drug; IF MORE THAN TEN ACTIVE/INACTIVE INGREDIENTS ARE BEING USED, LIST (INCLUDING NAME, NDC, QUANTITY, STRENGTH, AND MEDICAL NECESSITY FOR EACH) AND EXPLAIN THE NEED FOR MORE THAN TEN IN ITEM NUMBER 30. Only the most cost effective and medically necessary ingredients should be used. Herbal supplements, such as resveratrol, lavender oil, and alpha-lipoic acid, cannot be authorized on this form and will cause the form to be returned to the provider. Herbal supplements are authorized only on an exception basis on approval by the OWCP Chief Medical Officer or his/her designee.

*Drug Name *NDC
*Quantity *Strength *Medically Necessary? ○ Yes ○ No
Add

29. *Is the compounded drug medically necessary for its intended use? ○ Yes ○ No

30. * Provide a narrative explaining why the compounded drug is medically necessary, including why no commercially available (non-compounded) drug is sufficient. You may cite relevant medical literature to support your opinion. You may be asked to provide clinical documentation and other relevant evidence to support use of this medication including demonstrated improvement in both pain and function. The need for this medication is subject to review by claims staff and medical professionals. See instructions on item 28 if the compounded drug has more than ten ingredients.

I certify that I am the treating physician for the above-named patient and that the medication requested is medically necessary and cost effective for the patient. I further certify, under penalty of law, that the information provided on this form is true and correct to the best of my knowledge, and that documentation supporting this information is available for review if requested. I understand that any person who knowingly makes any false statement or misrepresentation to obtain prescription drugs from OWCP is subject to administrative penalties including provider exclusion; civil penalties including those under the False Claims Act and/or criminal prosecution. The submission of this form signifies my certification of the above and the on-file signature on my provider enrollment form is hereby incorporated by reference.

31. *Signature/CERTIFICATION of Patient's Treating Physician * ☐ Yes 32. Date mm 10 dd 26 ccyy 2016

* denotes required fields

Submit Reset