

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

mm dd yyyy  
[ ] [ ] [ ]

23. \*Route of Administration (and Code)

- 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

[ ]

24. \*Anticipated Length of Therapy:

[ ]

**Part D - Certification of Medical**

25. \*Has the patient tried and failed to use over-the-counter or other prescribed products for the diagnosis provided?

Yes  No

26. \*Are there commercially available products that are more appropriate for the diagnosis?

Yes  No

27. \*Are all of the active ingredients of the drug approved for the diagnosis provided? If no, please explain below

Yes  No

**Ingredients**

28. Complete the following for each active ingredient (ACTIVE/INACTIVE INGREDIENTS ARE LISTED IN ORDER OF NECESSITY FOR EACH) AND EXPLAIN WHY EACH IS NECESSARY AND MEDICALLY NECESSARY INGREDIENTS ARE LISTED LAST. If an ingredient is an acid, cannot be authorized on this form and is not a controlled substance, it may be authorized only on an exception basis.

29. List all ingredients in the compounded drug; IF MORE THAN TEN LIST THE FIRST TEN IN ITEM NUMBER 30. Only the most cost effective ingredients should be listed. Herbal supplements, such as resveratrol, lavender oil, and alpha-lipoic acid, cannot be returned to the provider. Herbal supplements are not controlled substances. Chief Medical Officer or his/her designee.

\*Drug Name [ ]

\*Quantity [ ]

\*Medically Necessary?  Yes  No