

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 Necessity

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 for the diagnosis? ☐ Yes ☐ No

27. *Are all of the active ingredients of the compounded drug approved for the diagnosis? ☐ Yes ☐ No

28. Complete the following for each active ingredient (ACTIVE/INACTIVE INGREDIENTS ARE LISTED IN ITEM NUMBER 30. Only the most cost effective ingredients, such as resveratrol, lavender oil, and alpha-lipoic acid, cannot be authorized on this form. Herbal supplements are authorized only on an exception basis.)

Ingredients	Drug Name	Quantity	Medically Necessary?
			☐ Yes ☐ No