



Complete form and fax to 1-877-533-2405. Fidelis Care will notify you within 3 business days as to what determination has been made. If you have any questions, please dial 1-888-FIDELIS (1-888-343-3547) and follow the appropriate prompts. To avoid unnecessary delays, PLEASE PRINT NEATLY AND COMPLETE THE FORM IN ITS ENTIRETY.

Member name (last, first) \_\_\_\_\_ Member ID # \_\_\_\_\_

DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex Male  Female

Prescriber name \_\_\_\_\_ Specialty \_\_\_\_\_ Contact Person \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

Phone # \_\_\_\_\_ Ext \_\_\_\_\_ Fax # \_\_\_\_\_

Medical Benefit Requests Only

J-code \_\_\_\_\_ Units Requested \_\_\_\_\_ Requested date(s) of service: \_\_\_\_\_

Facility Name \_\_\_\_\_ Tax ID # / NPI # \_\_\_\_\_

Medication Requested (strength, route, frequency, duration, and quantity) \_\_\_\_\_ Brand name only  Generic substitution OK

If applicable, please provide rationale for need of a non-preferred / non-formulary product \_\_\_\_\_

Current Diagnosis / ICD-10 and Other Significant Medical History (hard copy chart notes preferred) \_\_\_\_\_

Relevant lab results, x-rays, diagnostic tests supporting request, or verify absence of contraindications (hard copy lab results preferred) \_\_\_\_\_

Relevant past/present therapy (RX, OTC, non-pharmacological): (Must include dates to avoid delays; attach comprehensive list from chart notes)

Table with 4 columns: Drug (dose, route, frequency), Start Date, Stop Date, Detailed Outcome. Contains 4 empty rows for data entry.

How will the therapeutic outcome of this drug be monitored, including adverse drug events? \_\_\_\_\_

What is the baseline of this outcome prior to starting therapy? \_\_\_\_\_

Has the patient previously been on the requested medication? Yes  No  (If yes, provide start date and explain benefit of therapy)

Important: Please provide relevant clinical information that will help us to facilitate processing of your request including but not limited to: (MUST BE INCLUDED TO AVOID DELAYS; member chart notes, hard copy of lab results preferred)

- List of medical conditions and tests to include: Rheumatoid Arthritis, Multiple Sclerosis, Erythropoietins, Colony Stimulating Factor, Growth Hormone, IV iron, Enteral Nutrition, Hepatitis C, Xolair, Synagis, Hyperlipidemia, Diabetes, Androgens, HIV.

URGENT REQUEST CHECK  If the request is for a life threatening condition that is dependent on a priority review from the Fidelis Care Pharmacy Department (such as cardiovascular conditions like arrhythmia), you may request an expedited review. Medications for hyperlipidemia, growth hormones, allergic rhinitis, and other non-urgent use will be completed within 3 days and will NOT be expedited. Please be considerate of other providers and patients who are also requesting prior authorization.

I attest that this information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. I understand that any person who knowingly makes or causes to be made a false record or statement that is material to a Medicaid MC claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts. As indicated in the NYSDOH Medicaid Update (2/201, Volume 3, No. 02), third party phone or fax requests will not be accepted. If a prescriber grants a pharmacy the authority to handle his/her PA requests, the prescriber's actions would be considered "patient steering," as this arrangement does not give the patient a choice as to where they go to get their drugs. Per the Medicaid Update, this action may be reported to the Office of Medicaid Inspector General.

Prescriber's Signature \_\_\_\_\_ Date \_\_\_\_\_