FIDELIS CARE MEDICATION REQUEST FORM (9/15/2016)

Copies of this form and additional information available at http://www.fideliscare.org/pharmacy

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)*

Drug *(dose, route, frequency)*	**Start Date**	**Stop Date**	**Detailed Outcome**

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)*

- Rheumatoid Arthritis: past and current DMARDs, PPD results, RF
- Multiple Sclerosis (MS): past drug history, outcomes, current progress, MRI
- Erythropoetins (Procrit, Aranesp): CBC (H/H), ferritin, transferrin saturation
- Colony Stimulating Factor (Neupogen, Leukine): CBC (ANC)
- Growth Hormone: growth chart, stim test, bone age, IGF1, IGFBP3, parental height
- IV iron: past oral iron use, Hgb, Hct
- Enteral Nutrition: feeding tube, malabsorption disorder, B-code for medical benefit
- Hepatitis C: see specialized form found at http://www.fideliscare.org/pharmacy
- Xolair: IgE level, results of skin/blood test, FEV1
- Synagis: member's gestational age and risk factors
- Hyperlipidemia: past statin use, recent lipid panel
- Diabetes: latest A1C results, past metformin use with doses
- Androgens: total testosterone level collected by 10am (hard copy required)
- HIV: viral load, resistance testing, tropism testing, treatment history

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** _____