

**FIDELIS CARE NEW YORK (FCNY)
MEDICATION REQUEST FORM**

Please complete this form and fax it to Fidelis at **1-877-533-2405**. Fidelis will notify you within 3 business days as to what determination has been made. If you have any questions, please dial **1-888-343-3547** and follow prompts as a provider requesting a pharmacy authorization.

Member name _____ Member ID# _____

Line Of Business (check one):

FCNY Medicaid FCNY Child Health Plus FCNY Family Health Plus

Xolair Only

Prescriber Name (Please Print) _____

Prescriber Specialty (e.g., family medicine, psychiatry, etc) _____

Prescriber Phone Number _____ Fax Number _____ County _____

Prescriber Address _____

Medication Requested (Please include strength, quantity and/or duration of treatment):

1. What is the clinical condition or indication for the medication requested? (diagnosis)

2. Age _____ DOB _____ Sex _____ Wt _____ (kg/lbs) Ht _____ (inches/cm)

3. How long has the patient been treated with the requested medication (months/years), and is she/he stabilized on this treatment?

4. Please list which formulary drugs has the member tried, and what was the outcome?

5. Will you be using the requested medication for an "off-label" use?

Prescriber's signature _____ Date: _____

Please, utilize this space to provide any additional relevant clinical information, that will help us to facilitate processing of your request, including, but not limited to:

- For Diabetes Meds, please fax or include latest A1C results on the form.
- When requesting Ambien and like drugs please indicate etiology of Insomnia
- For hyperlipidemia, please fax latest LDL, TG, HDL, TC and the date of the lab tests.
- When requesting drugs for onychomycosis, please fax fungal culture, KOH, DTM or PAS results.