FIDELIS CARE®

Medical Drug Authorization Request
Drug Prior Authorization Requests Supplied by the Physician/Facility

Instructions: To ensure our members receive quality care, appropriate claims payment, and notification of servicing providers, please complete this form in its entirety. **Fax completed form to 1-888-481-7703.**

By using this form, the physician (or prescriber) is asking for Medical drug coverage meeting one or both criteria:

1. The drug is being supplied and administered in the physician's office. Provider will bill the health plan directly.
2. The drug is being supplied and administered at a facility or outpatient center. Facility/outpatient center will bill the health plan directly.

Who is making this request? ☐ Provider ☐ Member ☐ Appointed Representative

Appointed Representatives: Please include a signed Appointment of Representative form (CMS-1696) or equivalent notice.

Please indicate:

☐ Start of treatment: Start date _____/_____/_____

☐ Continuation of therapy: Date of last treatment _____/_____/_____

Priority Level		
☐ **Expedited**	☐ **Standard**	☐ **Post-service**

Appointed Representative **Complete the following section ONLY if the person making this request is not the member or prescriber:**	
Requestor's Name:	Requestor's Relationship to Member:
Address, City, State, ZIP:	
Requestor's Phone:	

Member	
Member Name:	Member ID#:
Member Address, City, State, ZIP:	
Phone:	DOB:

Ht/Wt (lb/kg):	Allergies:	ICD-10:

Requesting Provider		
Plan Provider ID Number:	NPI Number:	
Last Name:	First Name:	
Street Address:	City, State:	ZIP:
Phone Number	Fax Number:	
Provider Type/Specialty:	Name of Requestor:	

Treating Provider/Vendor		
☐ Out of Network If Yes, Please Provide Reason:		
Plan Provider ID Number:	NPI Number:	
Last Name:	First Name:	
Street Address:	City, State:	ZIP:
Phone Number	Fax Number:	
Provider Type/Specialty:	Name of Requestor:	

Facility Information		
Type: ☐ Office ☐ OP Hospital ☐ Home-Infusion/DME Provider Tax ID:		
Plan Provider ID Number:	NPI Number:	
Facility Name:	Phone Number:	Fax Number:
Street Address:	City, State:	ZIP:

Medication/Service Requested			
Medication/HCPCS Code (s)	Dose	Visits/Frequency	Length of Treatment

(Please use another form if more lines are needed.) **Physician Signature:**

_____

Document clinical rationale for override/exception request. List names and doses of previous medication(s) tried and failed. Fax all supporting documentation.

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