**Note**: Processing may be delayed if information submitted is illegible or incomplete.

If your fax includes the standardized fax form, only the **Member Name**, **DOB**, **ID**, and **Clinical Criteria** need to be completed and faxed as an attachment to process your request.

# ENROLLEE INFORMATION

**Enrollee’s Last Name: Enrollee’s First Name:**

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**Date of Birth: Enrollee’s Medicaid ID (2 letters, 5 numbers, 1 letter):**

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# PRESCRIBER INFORMATION

**Prescriber’s Last Name: Prescriber’s First Name:**

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**Contact Person:**

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**National Provider Identifier (NPI) Number:**

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**Office Phone Number: Office Fax Number:**

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# CLINICAL CRITERIA FOR TOPICAL COMPOUNDS

*(This section must be completed before a prior authorization will be issued.)*

1. Please provide the condition for which this compound is intended to treat:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please provide the route of administration for the compound:

[ ]  Topical [ ]  Oral [ ]  Other Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Is a similar commercially-available product available?

[ ]  Yes [ ]  No

If **YES**, please indicate why a commercially-available product is not acceptable and include the specific need for the compound:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. Is the active ingredient(s) of the compound FDA-approved for the condition being treated in the requested route of administration?

[ ]  Yes [ ]  No

If **NO**, please attach and submit peer-reviewed medical evidence for support.

1. Has the patient failed other therapies for this diagnosis?

[ ]  Yes [ ]  No

If **YES**, please provide the previously failed therapies:

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 *(Form continued on next page.)*

**Enrollee’s Last Name: Enrollee’s First Name:**

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List the NDC, name, dosage form, strength, and quantity of each ingredient. **Each ingredient used in the compound MUST be listed. Begin the list with the covered legend drugs. Please attach an additional form if compound has greater than 10 ingredients.**

 **Rx Required Active Ingredient Base/Vehicle Excipient/Other NDC Drug Name Dosage Form/Strength Quantity**

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| Prescriber Signature (Required)*I attest that this is medically necessary for this patient and that all of the information on this form is accurate to the best of my knowledge. I attest that documentation of the above diagnosis and medical necessity is available for review if requested by New York Medicaid.* |  | Date |

**Fax Number:** 1-800-268-2990

**Prior Authorization Call Line:** 1-877-309-9493

**Billing Questions:** 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit <http://newyork.fhsc.com> or call 1-877-309-9493.