Prescription Prior Authorization Level 3 Individual Request Form

Submission Instructions: Please complete this form and send it to the World Trade Center Health Program by posting it to the secure SFTP server and then sending an email to WTCMedCode@csc.com indicating the secure server posting of this request. Incomplete forms will be sent back for more information. Not to be used for formulary additions. DO NOT FILL OUT WTCHP PROGRAM SECTION.

Requester Information

Request Date

Choose a CCE/NPN

Requester Name

Requester Title/Role

Requester E-mail

Requester Phone

Clinical Director Name

Clinical Director Signature

Request Urgency

- ◯ Urgent
- ◯ Routine

Urgency Rationale

Member Information

Member Name

Member 911#

Member Date of Birth

Relevant Certification Condition(s)

ICD Code

Relevant Certification Condition(s)

ICD Code

Drug Information

Brand Name of Medication Requested:

Generic Name of Medication Requested:

Is the medication available generically?

Is this a newly FDA approved medication?

Is this a newly approved indication for a previously approved medication?

Drug Class:

When is this drug indicated during the normal course of treatment?

- ☐ 1st line
- ☐ 2nd line
- ☐ Last resort for treatment
- ☐ Other

If not indicated for the first line therapy, what medications or therapies are indicated for use prior to this medication?

Does this medication require special monitoring and/or participation in a patient registration program?

If yes, explain.

Is this an Orphan Drug?

Prescribing Information

What dosage form is being requested?

Is it a compound medication?

What is the prescribed strength?

What is the prescribed directions?

What is the expected duration of treatment with this drug? (maintenance, 14 day course etc)

Is this dosage/directions for use FDA approved for this member's condition?

When is this drug indicated during the normal course of treatment?

- ☐ 1st line
- ☐ 2nd line
- ☐ Last resort for treatment
- ☐ Other

What medications or therapies are indicated for use before this medication?

Please list currently available formulary medications, if any, which have been tried and failed by this member. Please include dates the medication was taken.

Did the member experience an adverse event or drug interaction with preferred medications that caused a discontinuation of therapy?

If yes, explain:

What is the expected cost of this medication?

Why does the prescribing provider believe this medication is considered medically necessary to treat this members condition?

Will delay in receipt of this medication result in a unfavorable and/or potentially fatal outcome?

Narrative: Please provide other required information per the formulary guidelines. Please provide supporting documentation on the safety and effectiveness of this drug (package insert, Journal citation):

TO BE FILLED OUT BY A WTCHP PROGRAM REVIEWER

Name

Credentials

WTCHP Program Decision

Signature

WTCHP Program Decision Comments