Prior Authorization Level 3 Renewal Form

SENSITIVE BUT UNCLASSIFIED

This form is to be completed and signed by the CCE/NPN Medical Director and should only be used for prescriptions renewed through the World Trade Center Health Program (WTCHP).

The CCE/NPN should upload this completed form into VitalPoint and inform the PBM and the WTCHP of this request via the SAMS messaging system. Not to be used for formulary additions.

Member Information | **Provider/Requestor Information**

Request Date:	☐ Survivor ☐ Responder	Requestor Name:	Requestor Credentials:
Member Name:	Date of Birth:	Requestor Fax:	Requestor Phone:
Member 911#:	CCE/NPN:	Request Email:	
Relevant Certified Condition(s) and ICD Code:		Request Urgency: Routine Urgent	
		Urgency Rationale:	

Prescribing Information

Brand Name:	Compound medication? Yes No
Generic Name:	Prescribed strength:
Drug Class:	Prescribed directions:
Dosage form/route of administration:	

When did the member start this medication?

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

Is the member using other medications concurrently to treat this condition? Yes No

If yes, please fill out table below.

Medication	Dosage	Dosing Schedule	Length of Therapy

Is there lab monitoring required for this medication? Yes No

If yes, please provide the results of the most recent lab:

Do these results show improvement in the member's condition and/or support continued use of the medication? Yes No

Please explain:

Has the member's condition improved since starting this medication? Yes ☐ No

If yes, please provide a description of the member's symptoms including frequency of occurrences of emergency room visits or hospitalizations?

Provide any additional information regarding the member's response to the requested medication.

TO BE FILLED OUT BY WTC HEALTH PROGRAM

Decision:

Decision Comments:

By signing below, I certify that the above information is correct and accurate to the best of my knowledge.

_____ _____

WTCHP (NIOSH) Signature Date

_____ _____

CCE/NPN Medical Director (or Designee) Signature Date

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