# Prior Authorization Request Form
# Airway Medications

**SENSITIVE BUT UNCLASSIFIED**

This form is to be completed and signed by the CCE/NPN Medical Director and should only be used for prescriptions to be filled 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.

**Please provide the following member and prescriber information (please print):**

Member Name: _____ Prescriber Name: _____

Member ID: _____ Prescriber Address: _____

CCE/NPN: _____ _____

Requested Medication: _____ Prescriber Phone #: _____

**Please complete the following clinical assessment:**

**1.** Is the member certified for the following conditions?

☐ Yes (Asthma) **Go to question 2** ☐ Yes (COPD) **Go to question 2** ☐ No **Medication not covered**

**2.** Answer the following questions below the applicable medication.

**AirDuo, RespiClick**

**A.** Patient has asthma as a certified condition,

**AND**

Patient requires salmeterol as the LABA component,

**AND**

Patient requires the lower dose found in AirDuo versus Advair Diskus or HFA

☐ Yes **Sign and date below**

☐ No **Medication not covered**

**OR**

**B.** Patient requires fluticasone/salmeterol and cannot manipulate the Advair Diskus or Advair HFA metered dose inhaler

☐ Yes **Sign and date below**

**Arnuity Elipta/Armon Air**

**A.** For existing members, have they failed a trial of Flovent Discus or HFA with inadequate a response or intolerable side effect or have a contraindication?

☐ Yes **Sign and date below**

☐ No **Medication not covered**

**OR**

**B.** Is this an incoming new member who is already well controlled on this medication?

☐ Yes **Sign and date below**

**Bevespi Aerosphere**

**A.** Does the patient have a COPD certification?

**AND**

Does the patient experience adverse effects or documented failure when using a dry powder inhaler and requires a MDI?

☐ Yes **Sign and date below**

☐ No **Medication not covered**

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Form continued on next page

**Seebri Neohaler**

**A.** Does the patient have a COPD certification?

**AND**

**B.** Does the patient experience adverse effects or documented failure of formulary agents:

☐ Yes **Sign and date below** ☐ No **Medication not covered**

Atrovent ☐

Tudorza ☐

Spiriva or ☐

PA 2 Incruse Ellipta ☐

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**Striverdi Respimat, Utibron Neohaler**

**A.** Does the patient have a COPD certification?

**AND**

Does the patient experience adverse effects or documented failure of formulary agent Anora Ellipta?

☐ Yes **Sign and date below** ☐ No **Medication not covered**

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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

Additional information may be attached to this document if needed.