



Prior Authorization Request Form Non-formulary Antipsychotics



****SENSITIVE BUT UNCLASSIFIED****

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

The CCE 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: _____	_____
Requested Medication: _____	Prescriber Phone #: _____

Please complete the following clinical assessment:

- | | | |
|---|-----------------------------------|------------------------------------|
| 1. Is the certified condition being treated major depressive disorder?
condition? | Yes
Skip to question 4 | No
Proceed to question 2 |
| 2. Is the certified condition being treated post-traumatic stress
disorder? | Yes
Skip to question 4 | No
Proceed to question 3 |
| 3. Is the certified condition being treated related to another mental
health condition? | Yes
Skip to question 4 | No
Coverage not approved |
| If so, please describe the condition: _____ | | |
| 4. Has the member previously responded to the requested non-
formulary medication and changing to a formulary medication would
introduce unacceptable clinical risk(s) to the member? | Yes
Sign and date below | No
Proceed to question 5 |
| 5. Has the member failed treatment with at least TWO formulary
atypical antipsychotic medications? | Yes
Sign and date below | No
Coverage not approved |

Please circle the reason(s) why the member cannot be treated with the following formulary medications:

- Use of formulary medication(s) is contraindicated.
- Member has experienced significant adverse effects from formulary medication(s).
- Use of formulary medication(s) has resulted in a therapeutic failure.

Aripiprazole (Abilify)	1	2	3	Paliperidone (Invega)	1	2	3
Asenapine (Saphris)	1	2	3	Quetiapine (Seroquel)	1	2	3
Latuda (Lurasidone)	1	2	3	Risperidone (Risperdal)	1	2	3
Olanzapine (Zyprexa)	1	2	3	Ziprasidone (Geodon)	1	2	3

**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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