Prior Authorization Request Form
Injectable Epinephrine (Epi-Pen) Quantity Limit Override
Current limit 1 (one) package per 90 days

SENSITIVE BUT UNCLASSIFIED

This form is to be completed and signed by the prescriber and 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: ___________________________

Member ID: ______________________________

CCE/NPN: _______________________________

Requested Medication: ____________________

Prescriber Name: ____________________________

Prescriber Address: ____________________________

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Prescriber Phone #: ____________________________

		Yes	No
1.	Does member have severe and uncontrolled asthma?	Go to question 2	Override not processed
2.	Has the member's previous supply been used?	Sign and date below Additional refill will be processed	Go to question 3
3.	Is the member's previous supply expired?	Sign and date below Additional refill will be processed	Override not processed

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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Additional information may be attached to this document if needed.