



Prior Authorization Request Form Non-formulary Diabetes Insulin



****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.

This form is to be used for these non-formulary drugs., Basal Insulins: Tresiba (degludec), Basaglar (glargine). Rapid Acting Insulins: Ademlog (lispro), Fiasp (aspart), Apidra (glulisine), Afrezza (inhaled human insulin).

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

Member Name: _____	Prescriber Name: _____
Member ID: _____	Prescriber Address: _____
CCE/NPN: _____	_____
Requested Medication: _____	Prescriber Phone #: _____

All diabetes medications should have the following PA2: Requires certification and its complications secondary to WTC-related conditions:

Please complete the following clinical assessment:

PA-3 criteria for the following insulins:

Basal Insulins

- | | | |
|--|------------------------------|-----------------------------|
| 1. Does the member have a diagnosis Type 1 Diabetes? | Yes
Proceed to question 2 | No
Coverage not approved |
| 2. Has the member tried and failed Lantus? | Yes
Proceed to question 3 | No
Coverage not approved |
| 3. Has the member tried and failed Levemir? | Yes
Sign and date below | No
Coverage not approved |

Rapid Acting Insulins

- | | | |
|--|------------------------------|-----------------------------|
| 1. Does the member have a diagnosis Type 1 Diabetes? | Yes
Proceed to question 2 | No
Coverage not approved |
| 2. Has the member tried and failed insulin aspart (Novolog)? | Yes
Proceed to question 3 | No
Coverage not approved |
| 3. Has the Member tried and failed insulin lispro (Humalog)? | Yes
Sign and date below | No
Coverage not approved |

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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