



# Prior Authorization Request Form Methadone

**\*\*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. Are alternative analgesic treatment options ineffective, not tolerated, or would be otherwise inadequate to provide sufficient pain management? | Yes<br>Sign and date below | No<br>Coverage not approved |
|--|----------------------------|-----------------------------|

<b>TO BE FILLED OUT BY WTC HEALTH PROGRAM</b>  Decision:  Decision Comments:	By signing below, I certify that the above information is correct and accurate to the best of my knowledge.  <table border="0" style="width: 100%;"> <tr> <td style="width: 60%; border-top: 1px solid black;">WTCHP (NIOSH) Signature</td> <td style="width: 40%; border-top: 1px solid black;">Date</td> </tr> <tr> <td style="border-top: 1px solid black;">CCE/NPN Medical Director (or Designee) Signature</td> <td style="border-top: 1px solid black;">Date</td> </tr> </table>	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.

Effective 10/4/2018

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