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 ☐

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**

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.