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: _____

Member ID: _____

CCE/NPN: _____

Requested Medication: _____

Prescriber Name: _____

Prescriber Address: _____

_____

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 **Sign and date below**

☐ No **Coverage not approved**

TO BE FILLED OUT BY WTC HEALTH PROGRAM	By signing below, I certify that the above information is correct and accurate to the best of my knowledge.
Decision:	_____ WTCHP (NIOSH) Signature _____ Date
Decision Comments:	_____ CCE/NPN Medical Director (or Designee) Signature _____ Date

Additional information may be attached to this document if needed.

Effective 10/4/2018

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