



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
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. <table border="0" style="width: 100%;"> <tr> <td style="width: 60%; border-top: 1px solid black; padding-top: 5px;">WTCHP (NIOSH) Signature</td> <td style="width: 40%; border-top: 1px solid black; padding-top: 5px;">Date</td> </tr> <tr> <td style="border-top: 1px solid black; padding-top: 5px;">CCE/NPN Medical Director (or Designee) Signature</td> <td style="border-top: 1px solid black; padding-top: 5px;">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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