Prior Authorization Request Form
Non-formulary Abuse Deterrents

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.

This form is to be used for these non-formulary drugs: Hysingla ER (hydrocodone), Embeda (morphine sulfate; naltrexone), Arymo ER (morphine sulfate), MorphaBond XR (morphine sulfate), Xtampza ER (oxycodone), RoxyBond (oxycodone).

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. Has the member tried and failed at least TWO formulary narcotic analgesics?

☐ 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

Additional information may be attached to this document if needed.

Effective 10/4/2018

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