Prescription Prior Authorization Level 3 Individual Request Form

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. Not to be used for formulary additions.

Member Information | **Provider/Requestor Information**

Request Date:	☐ Survivor ☐ Responder	Requestor Name:	Requestor Credentials:
Member Name:	Date of Birth:	Requestor Fax:	Requestor Phone:
Member 911#:	CCE/NPN:	Request Email:	
Relevant Certified Condition(s) and ICD Code:		Request Urgency: Routine Urgent	
		Urgency Rationale:	

Drug Information

Brand Name:	Compound medication? Yes No
Generic Name:	Prescribed strength:
Drug Class:	Prescribed directions:
Dosage form/route of administration:	

What is the expected duration of treatment with this drug? (Maintenance, 14 day course, etc.)

What is the estimated cost of this medication per month or over the course of treatment?

Is this dosage/directions for the use FDA approved for this member's condition or recognized as an off-label use in the accept compendia? ☐ Yes ☐ No

If No – then this request is for "off-label" use. Please provide medical rationale for use, and supporting documentation.

When is this drug indicated during the normal course of treatment?

☐ 1st Line ☐ 2nd Line ☐ Last resort for treatment ☐ Other

Please list the medications currently and previously used by the member to treat this condition:

Medication	Dosage	Dosing Schedule	Length of Therapy

Did the member experience and adverse event or drug interaction with preferred medications that caused a discontinuation of therapy? Yes No

If yes, please explain:

Does this medication require special monitoring and/or participation in a patient registration program? Yes ☐ No

Please describe the member's WTC certified condition that will be treated by this medication.

If applicable, please provide any supporting lab test results that may justify the use of the medication.

Has the member taken this medication for this condition before? Yes ☐ No

If yes, please explain:

Provide any additional medical rationale relevant to this member's case:

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

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