

Prior Authorization Request Form Non-formulary Antipsychotics



SENSITIVE BUT UNCLASSIFIED

This form is to be completed and signed by the CCE Medical Director and should only be used for prescriptions to be filled through the World Trade Center Health Program (WTCHP).

The CCE 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 i | member and | prescr | riber info | ormation (pleas | se pi | rint): | | | | | |
|--|---|---------------------|------------------------|--------------------|--------|--|---------------------|----------------------|--|-----------------------------|--|
| Member Name: | | - | Prescriber | Nam | ne: | | | | | | |
| Member ID: | | Prescriber Address: | | | | | | | | | |
| CCE: | | | | | | | | | . <u></u> | | |
| Requested Medication: | | Prescriber | Pho | ne #: | | | | | | | |
| Please complete the following | g clinical ass | essme | ent: | | | | | | | | |
| 1. Is the certified condition condition? | Is the certified condition being treated major depressive disorder? condition? | | | | | Yes Skip to question 4 | | | No Proceed to que | stion 2 | |
| | | | | | | Yes Skip to question 4 | | | No Proceed to que | No Proceed to question 3 | |
| 3. Is the certified condition health condition? | 3. Is the certified condition being treated related to another mental health condition? Yes Skip to question 4 | | | | | | | No Coverage not a | pproved | | |
| If so, please describe the | e condition: | | | | | | | | | | |
| | | | | | | Yes Sign and date bel | ow | | No Proceed to que | stion 5 | |
| 5. Has the member failed treatment with at least TWO formulary atypical antipsychotic medications? | | | | | | Yes Sign and date bel | ow | | No Coverage not a | pproved | |
| Please circle the reason the following formulary n | | ember | cannot b | e treated with | 2. | Member has experienced formulary medical | erience tion(s). | d sign |) is contraindicated. ificant adverse effe) has resulted in a t | cts from | |
| Aripiprazole (Abi | ilify) 1 | 1 2 | 3 | Palipe | ridor | ne (Invega) | 1 | 2 | 3 | | |
| Asenapine (Sap | • • | 1 2 | 3 | - | | (Seroquel) | 1 | 2 | 3 | | |
| Latuda (Lurasido | one) 1 | 1 2 | 3 | Risper | idon | e (Risperdal) | 1 | 2 | 3 | | |
| Olanzapine (Zyprexa) 1 | | 1 2 | 3 Ziprasidone (Geodon) | | | e (Geodon) | 1 | 2 | 3 | | |
| TO BE FILLED OUT BY WTC HEALTH PROGRAM | | | • | t the above inform | natior | n is correct and acc | curate | to the | best of my knowled | ge. | |
| Decision: Decision Comments: | WTCHP (NI | | | r Designee) Signa | ature | Date Date | | | | | |