Prior Authorization Request Form
Injectable Epinephrine (Epi-Pen) Quantity Limit Override
Current limit 1 (one) package per 90 days

SENSITIVE BUT UNCLASSIFIED

This form is to be completed and signed by the prescriber and 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 #: ___________________________

Question	Yes	No
1. Does member have severe and uncontrolled asthma?	Yes Go to question 2	No Override not processed
2. Has the member's previous supply been used?	Yes Sign and date below Additional refill will be processed	No Go to question 3
3. Is the member's previous supply expired?	Yes Sign and date below Additional refill will be processed	No Override not processed

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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Additional information may be attached to this document if needed.