Prior Authorization Request Form
Non-formulary Diabetes Insulin

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.

This form is to be used for these non-formulary drugs., Basal Insulins: Tresiba (degludec), Basaglar (glargine). Rapid Acting Insulins: Ademlog (lispro), Fiasp (aspart), Apidra (glulisine), Afrezza (inhaled human insulin).

Please provide the following member and prescriber information (please print):

Member Name:________________________ Prescriber Name: ___________________________

Member ID:___________________________ Prescriber Address: ___________________________

CCE/NPN:_____________________________ ___________________________

Requested Medication:__________________ Prescriber Phone #: ___________________________

All diabetes medications should have the following PA2: Requires certification and its complications secondary to WTC-related conditions:

Please complete the following clinical assessment:

PA-3 criteria for the following insulins:

Basal Insulins

Question	Yes	No
1. Does the member have a diagnosis Type 1 Diabetes?	Yes **Proceed to question 2**	No **Coverage not approved**
2. Has the member tried and failed Lantus?	Yes **Proceed to question 3**	No **Coverage not approved**
3. Has the member tried and failed Levemir?	Yes **Sign and date below**	No **Coverage not approved**

Rapid Acting Insulins

Question	Yes	No
1. Does the member have a diagnosis Type 1 Diabetes?	Yes **Proceed to question 2**	No **Coverage not approved**
2. Has the member tried and failed insulin aspart (Novolog)?	Yes **Proceed to question 3**	No **Coverage not approved**
3. Has the Member tried and failed insulin lispro (Humalog)?	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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