



Prior Authorization Request Form Airway Medications



****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.

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

Member Name: _____	Prescriber Name: _____
Member ID: _____	Prescriber Address: _____
CCE/NPN: _____	_____
Requested Medication: _____	Prescriber Phone #: _____

Please complete the following clinical assessment:

- Is the member certified for the following conditions?

Yes (Asthma) Go to question 2	Yes (COPD) Go to question 2	No Medication not covered
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- Answer the following questions below the applicable medication.

AirDuo, RespiClick

A. Patient has asthma as a certified condition,

AND

Patient requires salmeterol as the LABA component,

AND

Patient requires the lower dose found in AirDuo versus Advair Diskus or HFA

OR

B. Patient requires fluticasone/salmeterol and cannot manipulate the Advair Diskus or Advair HFA metered dose inhaler

Yes
Sign and date below

No
Medication not covered

Yes
Sign and date below

Arnuity Elipta/Armon Air

A. For existing members, have they failed a trial of Flovent Discus or HFA with inadequate a response or intolerable side effect or have a contraindication?

OR

B. Is this an incoming new member who is already well controlled on this medication?

Yes
Sign and date below

No
Medication not covered

Yes
Sign and date below

Bevespi Aerosphere

A. Does the patient have a COPD certification?

AND

Does the patient experience adverse effects or documented failure when using a dry powder inhaler and requires a MDI?

Yes
Sign and date below

No
Medication not covered

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Seebri Neohaler

A. Does the patient have a COPD certification?

AND

B. Does the patient experience adverse effects or documented failure of formulary agents:

Yes
Sign and date below

No
Medication not covered

Atrovent

Tudorza

Spiriva or

PA 2 Incruse Ellipta

Striverdi Respimat, Utibron Neohaler

A. Does the patient have a COPD certification?

AND

Does the patient experience adverse effects or documented failure of formulary agent Anora Ellipta?

Yes
Sign and date below

No
Medication not covered

**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.