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 member and prescriber information (please print):

Member Name: _____

Member ID: _____

CCE: _____

Requested Medication: _____

Prescriber Name: _____

Prescriber Address: _____

_____

Prescriber Phone #: _____

Please complete the following clinical assessment:

1. Is the certified condition being treated major depressive disorder? condition?

☐ Yes **Skip to question 4** ☐ No **Proceed to question 2**

2. Is the certified condition being treated post-traumatic stress disorder?

☐ Yes **Skip to question 4** ☐ No **Proceed to question 3**

3. Is the certified condition being treated related to another mental health condition?

☐ Yes **Skip to question 4** ☐ No **Coverage not approved**

If so, please describe the condition: _____

4. Has the member previously responded to the requested non-formulary medication and changing to a formulary medication would introduce unacceptable clinical risk(s) to the member?

☐ Yes **Sign and date below** ☐ No **Proceed to question 5**

5. Has the member failed treatment with at least TWO formulary atypical antipsychotic medications?

☐ Yes **Sign and date below** ☐ No **Coverage not approved**

Please circle the reason(s) why the member cannot be treated with the following formulary medications:

1. Use of formulary medication(s) is contraindicated.
2. Member has experienced significant adverse effects from formulary medication(s).
3. Use of formulary medication(s) has resulted in a therapeutic failure.

Aripiprazole (Abilify)	1 2 3	Paliperidone (Invega)	1 2 3
Asenapine (Saphris)	1 2 3	Quetiapine (Seroquel)	1 2 3
Latuda (Lurasidone)	1 2 3	Risperidone (Risperdal)	1 2 3
Olanzapine (Zyprexa)	1 2 3	Ziprasidone (Geodon)	1 2 3

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 5/9/2018

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