



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.

Places provide the following	mambar and procesiber info	rmation (places print):	
Please provide the following member and prescriber info Member Name: Member ID:		Prescriber Address:	
Requested Medication:		Prescriber Phone #:	
Does member have asthma?	e severe and uncontrolled	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	By signing below, I certify that t	he above information is correct and accurate	to the best of my knowledge.
Decision: Decision Comments:	WTCHP (NIOSH) Signature	Date	

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CCE/NPN Medical Director (or Designee) Signature

Date