Dear Healthcare Provider:

Your patient, an active or retired member of the FDNY, is eligible for the FDNY WTC Monitoring and Treatment Program, which can now provide him/her with free WTC-related medications. **The plan covers only respiratory, chronic sinus conditions, GERD, and mental health medications prescribed to address WTC health-related issues. All other conditions are NOT covered under this plan**.

Under this plan, your patient may be covered for medications that you have previously prescribed or are planning to prescribe. The WTC Prescription Plan will use approved generic medications, where available and medically indicated. If a member does not respond well to the generic, then brand name medications are available with FDNY BHS approval.

In order for your patient to take advantage of this program, he/she must fulfill the following requirements:

- He/she must have had a BHS WTC “annual” medical since August 12, 2005 and agree to keep that updated as directed
- **Please note**: Only WTC prescriptions written by BHS physicians are covered under this plan
- The attached Physician Certification form must be fully completed (please, as legibly as possible). The health care provider that has prescribed the medication(s) must sign the form, which must show the physician/practice stamp. Additional appropriate documentation would include any test results that bear on the medication(s) that you have prescribed
- Once the form has been reviewed by the FDNY WTC medical staff, your patient will be called to schedule a WTC Treatment appointment, at the Bureau of Health Services

This WTC medication plan is federally funded through the NIOSH WTC Treatment Program, co-designed by BHS & the Fire and EMS union partners – the UFA, UFOA and Locals 2507 and 3621. The duration of the expanded BHS WTC Treatment Program, including prescription medication reimbursement, is limited by the current appropriated federal funding, which, at this time, is probably for no more than one year. Efforts are being made to extend this funding, but there are no guarantees.

We would ask for your cooperation in this WTC Treatment Program to offer your patient this benefit. It is likely that medications you have been prescribing for your patient with WTC-related conditions – respiratory, chronic sinus, GERD, and mental health – are part of this Program’s formulary. If you have questions, please call 718-999-1858 for assistance.

Please complete the attached health care provider certification. The completed form, and any test results that influenced your prescribing and dosing decisions, should be faxed to (718) 999-0170, a fully secure machine. A BHS WTC nurse will review the information that you have provided. If any additional information is needed, the WTC nurse will contact your office. Once the form has been reviewed and verified as complete, a WTC staff member will call your FDNY patient/member to schedule a convenient WTC Treatment appointment with a BHS WTC health professional. Thank you for your participation in helping us at BHS provide your patient with the benefits of the free WTC Treatment Program.

Physician Certification for FDNY WTC Treatment Program

(Please fax fully completed form and any relevant test results to BHS, 718-999-0170)

This is to certify that (print name) ______________________________ is a patient under my care since (insert date) _______________ for the following medical condition(s):

☐ Respiratory (specify dx and ICD code): ____

☐ Sinus (specify dx and ICD code):____

☐ GERD (specify dx and ICD code): ____

☐ Mental Health (specify dx and DSM code): ____

The following appropriate studies have been performed to support this/these diagnosis(es) (please provide dates):____

Please complete **each item below** with the appropriate responses regarding your patient's care:

☐ 1. The WTC Prescription Plan will use approved generic medications, where available and medically indicated. If you list a brand medication below, please indicate if a generic substitution would **not** be allowed and provide justification on a separate page.

This patient is currently being maintained on the following medication(s):

Medication	Time Interval (days, months, years)	Prescription Strength	Dosing Regimen	Check if No Generics
____________________	______________	___________	__________	☐
____________________	______________	___________	__________	☐
____________________	______________	___________	__________	☐
____________________	______________	___________	__________	☐
____________________	______________	___________	__________	☐

☐ 2. This patient has been evaluated on this current treatment regimen and his/her condition is improved and stable at this time. Follow-up appointment is scheduled for ________________(date).

☐ 3. This patient is to initiate the following medication(s) within the auspices of the WTC Medications Treatment Program under my supervision (state medication(s) and doses):

____

Follow-up appointment is scheduled for _________________________ (date).

Physician's stamp here

Physician's signature:

____

Print Physician Name:______________________

License No:______________________________

Date: ___________________________________

Office No: _______________________________

NOTE: If you need more space, please make copies of this form and include all such copies when submitting to us. Thank you.

FDNY Office Use Only: ☐ A ☐ B ☐C

Confidential

WTC Prescriptions

WTC Fax

To:	FDNY BHS	**From:**	
Fax:	718-999-0170 (fully secure)	**Pages:**	
Phone:	718-999-1858	**Date:**	
Re:	**WTC Prescriptions - Physician Certification Form**		

The attached Physician Certification form contains prescription information for the following active/retired FDNY member:

- **Please PRINT clearly:**

Member Name: ____

Member Address: ____

City/State: ___________________________________ Zip: ____________

Member Phone Number: ___ ___ ___ - ___ ___ ___ - ___ ___ ___ ___

Member Date of Birth: ____/____/____

Last 4 digits of SSN: ___ ___ ___ ___