Quitline Iowa
1-800-784-8669

FAX Completed Form To
1-800-261-6259

Iowa Department of Human Services

Request for Prior Authorization
SMOKING CESSATION THERAPY-ORAL

(PLEASE PRINT – ACCURACY IS IMPORTANT)

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior Authorization is required for varenicline (Chantix™) or bupropion SR that is FDA approved for smoking cessation. Requests for authorization must include: 1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling. 2) Confirmation of enrollment and ongoing participation in the Quitline Iowa counseling program is required for approval and continued coverage. 3) Approvals will only be granted for patients eighteen years of age and older. 4) The duration of therapy is initially limited to twelve weeks within a twelve-month period. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment will be considered with a prior authorization request. The maximum duration of approvable therapy is 24 weeks within a twelve-month period. 5) Requests for varenicline to be used in combination with bupropion SR or nicotine replacement therapy will not be approved. 6) The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation

☐ Chantix™ Starter Pak ☐ Chantix™ 1mg BID ☐ Other: _____ **(**May check more than one box**)**

☐ Bupropion SR Strength_____ Dosing Instructions:_____

☐ **PA Renewal Prescriber signature on this line indicates medical documentation that the member has stopped smoking after the initial 12 weeks of therapy.** _____

☐ The patient has agreed to the following:
1) Volunteered to participate with Quitline Iowa **2)** Quitline Iowa may contact the patient about quitting smoking, local programs, and/or counseling **3)** Quitline Iowa may discuss the patient's use of Quitline with the patient's health care provider and/or Iowa Medicaid **4)** All the patient's information will be kept private

_____ _____ _____ _____
Patient's Signature Patient's Phone Number Preferred Language Hearing Impaired/Need TDD

Best times and days for Quitline to call:
☐ 8:00 a.m. to noon ☐ 8:00 p.m. midnight ☐ Best days to call:_____
☐ Noon to 4:00 p.m. ☐ Call at exact time:_____ ☐ The counselor may leave a message saying they are from Quitline Iowa
☐ 4:00 p.m. to 8:00 p.m.

Prescriber signature (Must match prescriber listed above.)	Date of submission

Prescriber: Please fax completed portion above to Quitline Iowa: 1-800-261-6259.

Outcome (to be completed by Quitline Iowa and faxed to the Iowa Medicaid PA Department at 1-800-574-2515):

☐ Member enrolled in Quitline Iowa Counseling Program ☐ Member disenrolled in Quitline Iowa Counseling Program

Date enrolled: _____ ☐ Date disenrolled: _____

IMPORTANT NOTE: *In evaluating requests for prior authorization the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary by contact with the county Department of Human Services, that the member continues to be eligible for Medicaid.*