Iowa Department of Public Health/Quitline Iowa REQUEST FOR PRIOR AUTHORIZATION

Nicotine Replacement Therapy

(PLEASE PRINT - ACCURACY IS IMPORTANT)

	(I ELIBET RITT TRECORTE	T IS IN OKTAVI)
IowaCare/Medicaid Member ID #:	Patient Name:	DOB:
Patient Address:		
Provider NPI: _ _ _ _	Prescriber Name:	Phone:
Prescriber Address:		Fax:
Pharmacy Name:	Address:	Phone:
Prescriber must fill all inform	ation above. It must be legible, cor	rect and complete or form will be returned.
Pharmacy		
•	Pharmacy Fax:	NDC :
3) Approvals will only be granted for total combined therapy within a twel oral nicotine replacement products (gum or 144 nicotine lozenges may be a 4 week supply at one unit per day of first 28 days of therapy, continuation for non-preferred nicotine replacement and preferred topical nicotine redispensed with the initial prescription inhalers or 80ml of nicotine nasal specessation. Preferred Nicotine Patches; 21mg/24 Hour	r patients eighteen years of age and older lye-month period. 5) Patients may receive gum or lozenges). A maximum quantity dispensed with the initial prescription. It is available only with documentation of ent products will be considered after doceplacement product. A maximum quantin. Subsequent prescription refills will be	
		rengui: zing 4mg
Non-Preferred: Nicotrol In	nhaler Nicotrol Nasal Spray	
	ct, please include documentation of a pact date ranges and intolerance reason	oreferred oral and topical nicotine replacement product as:
Diagnosis:	Date Referr	ed To Quitline Iowa:
	Quitline Iowa2) Quitline Iowa may consiscuss the patient's use of Quitline with	eact the patient about quitting smoking, local programs, and/or the member's health care provider and/or Iowa Medicaid4) All the
Patient's Signature	Patient's Phone Number	Preferred Language Hearing Impaired/Need TDD
Best times and days for Quitline to ca		_
	8:00 p.m. midnight	Best days to call:
	Call at exact time:	The counselor may leave a message saying
4:00 p.m. to 8:00 p.m.		they are from Quitline Iowa
Prescriber Signature:*MUST MATCH PRESCRIBER LISTED	APOVE	Date of Submission:
"MUST MATCH PRESCRIBER LISTED	ADUVE	

Completed form faxed to the Iowa Medicaid PA Department at 1-800-574-2515 by Quitline Iowa

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.