Quitline Iowa
1-800-784-8669

Iowa Department of Human Services

Request for Prior Authorization
NICOTINE REPLACEMENT THERAPY
(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1-800-261-6259

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 over-the-counter nicotine replacement patches, nicotine gum, or nicotine lozenges, and prescription nicotine nasal spray or nicotine inhaler. Requests for authorization must include: 1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling. 2) Confirmation of enrollment in the Quitline Iowa counseling program is required for approval. 3) Approvals will only be granted for patients eighteen years of age and older. 4) The maximum allowed duration of therapy is twelve weeks total combined therapy within a twelve-month period. 5) Patients may receive nicotine replacement patches in combination with one of the oral nicotine replacement products (gum or lozenges). A maximum quantity of 14 nicotine replacement patches and 110 pieces of nicotine gum or 144 nicotine lozenges may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be dispensed as a 4 week supply at one unit per day of nicotine replacement patches and 330 pieces of nicotine gum or 288 nicotine lozenges. Following the first 28 days of therapy, continuation is available only with documentation of ongoing participation in the Quitline Iowa program. 6) Requests for non-preferred nicotine replacement products will be considered after documentation of previous trials and intolerance with a preferred oral and preferred topical nicotine replacement product. A maximum quantity of 168 nicotine inhalers or 40ml nicotine nasal spray may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be dispensed as a 4 week supply at 336 nicotine inhalers or 80ml of nicotine nasal spray. 7) The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation.

Preferred:

Nicotine Patches; ☐ 21mg/24 Hour Patch ☐ 14mg/24 Hour Patch ☐ 7mg/24 Hour Patch

Nicotine Gum; ☐ 2mg ☐ 4mg **Nicotine Lozenge**; 144 Count Box Strength: ☐ 2mg ☐ 4mg

Non-Preferred: ☐ Nicotrol Inhaler ☐ Nicotrol Nasal Spray

If requesting non-preferred product, please include documentation of a preferred oral and topical nicotine replacement product including drug names, strength, exact date ranges and intolerance reasons:

_____

_____

Diagnosis: _____ **Date Referred To Quitline Iowa:** _____

☐ **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 member'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
Date enrolled: _____

☐ Member disenrolled with Quitline Iowa Counseling Program
☐ 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.*