pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

SMOKING CESSATION PRODUCTS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**
- To review the prior authorization guidelines for Smoking Cessation products, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Smoking Cessation** (accessible at: http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list at: http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm).

PRIOR AUTHORIZATION INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request ☐Additional info (PA# _____)	# of pages in request: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐NicoDerm CQ patch (OTC) ☐Nicorette lozenge (OTC) ☐Nicotrol NS nasal spray ☐Zyban tablet
☐Nicorette chewing gum (OTC) ☐Nicorette Mini lozenge (OTC) ☐Nicotrol cardtridge inhaler ☐_____

Strength:	Dose/directions:	Quantity:	Refills:

Diagnosis (*submit documentation*):	Dx code (*required*):

Complete section applicable to drug being requested.

Section A: Zyban requests

1. Has the Recipient tried and failed the preferred alternative Smoking Cessation product – bupropion SR 150 mg tablet (generic Zyban)?	☐Yes – *submit all supporting documentation of drug regimen tried and treatment outcomes* ☐No
2. Does the Recipient have any contraindications or intolerances to the preferred alternative Smoking Cessation product – bupropion SR 150 mg tablet (generic Zyban)?	☐Yes – *submit all supporting documentation of medication name and associated intolerances and contraindications* ☐No

Section B: All other requests

1. Has the Recipient tried and failed any of the preferred nicotine replacement products? *Check all that apply.* ☐nicotine gum (OTC) ☐nicotine lozenge (OTC) ☐nicotine transdermal patch (OTC)	☐Yes – *submit all supporting documentation of nicotine replacement product(s) tried and treatment outcomes* ☐No
2. Does the Recipient have any contraindications or intolerances to any of the preferred nicotine replacement products listed in question (1)?	☐Yes – *submit all supporting documentation of medication name and associated intolerances and contraindications* ☐No

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date**: