Quitline Iowa
1-800-784-8669

FAX Completed Form To
319-384-4841

Iowa Department of Public Health/Quitline Iowa
REQUEST FOR PRIOR AUTHORIZATION
Nicotine Replacement Therapy
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IA Medicaid
Member ID #: |___|___|___|___|___|___|___|___|___|___| Patient Name: _____ DOB: _____

Patient Address:_____

Iowa Medicaid
Provider Number: |___|___|___|___|___|___|___|___|___|___| Prescriber Name:_____ Phone:_____

Prescriber Address:_____ Fax:_____

Pharmacy Name:_____ Address:_____ Phone:_____

Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.

Pharmacy
IA Medicaid
Provider #: |___|___|___|___|___|___|___|___|___|___| Pharmacy Fax: _____ NDC : |___|___|___|___|___|___|___|___|___|___|___|

Prior Authorization is required for over-the-counter nicotine replacement patches and nicotine gum. 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 within a twelve-month period. 5) A maximum quantity of 14 nicotine replacement patches and/or 110 pieces of nicotine gum 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 /or 330 pieces of nicotine gum. Following the first 28 days of therapy, continuation is available only with documentation of ongoing participation in the Quitline Iowa program.

Preferred

Nicotine Patches; 14 Count Box Strength: ☐ 21mg/24 Hour Patch ☐ 14mg/24 Hour Patch ☐ 7mg/24 Hour Patch
Quantity: _____

Nicotine Gum; 110 Count Box Strength: ☐ 2mg ☐ 4mg Quantity: _____

Diagnosis: _____ Date Referred To Quitline Iowa: _____

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

_____ _____ _____ _____
Member's Signature | Member'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: _____ Date of Submission: _____
***MUST MATCH PRESCRIBER LISTED ABOVE**

Prescriber: Please fax completed portion above to Quitline Iowa: 319-384-4841.
Only one PA Request Required for 12 week treatment.

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 ☐ Counselors unable to make contact
Date enrolled: _____ ☐ Other: _____

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.