Alabama Medicaid Pharmacy
Smoking Cessation
Prior Authorization Request Form

FAX: (800) 748-0116
Phone: (800) 748-0130

Fax or Mail to
Health Information Designs

P.O. Box 3210
Auburn, AL 36832-3210

PATIENT INFORMATION

Patient Name ______________________________ Patient Medicaid # ______________________________

Patient DOB ______________________________ Patient Phone # with area code ______________________________

PRESCRIBER INFORMATION

Prescriber Name______________________________ NPI # ______________ License # ______________

Phone # with area code ______________________________ Fax # with area code ______________________________

Address (optional) ____

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.

____
Prescribing Provider Date

DRUG/CLINICAL INFORMATION

Drug requested* ______________________________ Strength ______________________________

Drug Code ____________________ Qty. per month ______________ Days supply ____________________

Duration of therapy ______________________________ ❒ Initial Request ❒ Renewal Request

A copy of the Department of Public Health's Alabama Tobacco Quitline Patient Referral/Consent Form signed by the recipient must be submitted to the Quitline. **Additionally, a copy of the Consent Form *must be* submitted along with this Prior Authorization Request form to Health Information Designs for approval.** The form can be found at http://www.adph.org/tobacco/assets/RefConsent2012.pdf.

Only one quit attempt will be approved per calendar year.

Plan First Recipients do not require prior approval for smoking cessation products. The Smoking Cessation Prior Authorization Request Form should not be submitted for those recipients.

*If the requested drug is a brand name drug with an exact generic equivalent available, the FDA MedWatch Form 3500 must be submitted to HID in addition to the PA Request Form.

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing Pharmacy ____ NPI # ____________________

Phone # with area code ______________________________ Fax # with area code ______________________________