

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/FaxReferralForm2014.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 _____
