

Iowa Department of Public Health/Quitline Iowa  
**REQUEST FOR PRIOR AUTHORIZATION**  
**Varenicline (Chantix™)**  
(PLEASE PRINT - ACCURACY IS IMPORTANT)

IowaCare/Medicaid Member ID #: _____	Patient Name: _____	DOB: _____
Patient Address: _____		
Provider ID/NPI: _____	Prescriber Name: _____	Phone: _____
Prescriber Address: _____		Fax: _____
Pharmacy Name: _____	Address: _____	Phone: _____
<b>Prescriber must fill all information above. It must be legible, correct and complete or form will be returned.</b>		
Pharmacy NABP or NPI: _____ Pharmacy Fax: _____ NDC : _____		

Prior Authorization is required for varenicline (Chantix™). Requests for authorization must include: 1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling. 2) Confirmation of enrollment and ongoing participation in the Quitline Iowa counseling program is required for approval and continued coverage. 3) Approvals will only be granted for patients eighteen years of age and older. 4) The duration of therapy is initially limited to twelve weeks within a twelve-month period. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment will be considered with a prior authorization request. The maximum duration of approvable therapy is 24 weeks within a twelve-month period. 5) Requests for varenicline to be used in combination with bupropion SR or nicotine replacement therapy will not be approved. 6) The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation

Chantix™ Starter Pak  Chantix™ 1mg BID  Other: \_\_\_\_\_ (\*\*May check more than one box\*\*)

PA Renewal Prescriber signature on this line indicates medical documentation that the member has stopped smoking after the initial 12 weeks of therapy. \_\_\_\_\_

- 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:

<input type="checkbox"/> 8:00 a.m. to noon	<input type="checkbox"/> 8:00 p.m. to midnight	<input type="checkbox"/> Best days to call: _____
<input type="checkbox"/> Noon to 4:00 p.m.	<input type="checkbox"/> Call at exact time: _____	<input type="checkbox"/> The counselor may leave a message saying they are from Quitline Iowa
<input type="checkbox"/> 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: 1-800-261-6259.**

**Outcome (to be completed by Quitline Iowa and faxed to the Iowa Medicaid PA Department at 1-800-574-2515):**

- |  |  |
|--|--|
| <input type="checkbox"/> Member enrolled in Quitline Iowa Counseling Program | <input type="checkbox"/> Counselors unable to make contact |
| Date enrolled: _____   | <input type="checkbox"/> 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.