

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: _____		
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 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. to 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: 1-800-261-6259.  
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.**