



PA19 - SMOKING CESSATION PRODUCTS
NOT required for recipients under 21 years of age.

Executive Office of Health & Human Services
PRIOR AUTHORIZATION REQUEST FORM for RI MEDICAID FEE FOR SERVICE (FFS)
HP Enterprise Services · 301 Metro Center Blvd., 3rd Floor · Warwick, RI 02886 · FAX 401-784-3889
ATTN : PHARMACIST

CLIENT NAME: _____ DOB: ____ / ____ / ____ MEDICAID ID NUMBER: _____

PRESCRIBER NAME: _____ PRESCRIBER NPI #: _____

PRESCRIBER OFFICE ADDRESS: _____

OFFICE PHONE NUMBER () _____ FAX NUMBER () _____

____ **INITIAL TREATMENT** (LIMITED TO 90 CONSECUTIVE DAYS)

INITIAL COUNSELING SESSION (REQUIRED): _____ 99406 DATE: _____

OR

____ **SUBSEQUENT TREATMENT** (MUST BE AT LEAST 30 DAY BREAK FROM INITIAL TREATMENT EXCEPT FOR CHANTIX)

FOLLOW-UP COUNSELING SESSION (RECOMMENDED) _____ 99407 DATE: _____

MEDICATION REQUESTED:

____ **BUPROPION SR 150MG**

____ **CHANTIX**

____ 0.5MG TABLETS

____ STARTER PACK (PREPACKAGED AS 0.5MG X 11 TABS AND 1MG X 42 TABS)

____ 1.0 MG TABLETS

____ CONTINUATION PACK (PREPACKAGED AS 1MG X 56 TABS)

____ **NICOTINE**

____ PATCH (LIST ALL STRENGTHS THAT APPLY)

____ 21MG /24 HR

____ 14 MG/24 HR

____ 7 MG/24 HR

____ GUM* _____ 2MG _____ 4MG

____ LOZENGE* _____ 2MG _____ 4MG

____ INHALER*

____ SPRAY*

*PLEASE INDICATE MEDICAL JUSTIFICATION OF THESE PRODUCTS OVER CHANTIX, PATCHES OR BUPROPION AND/OR IF THIS IS CONTINUATION THERAPY, WHY CONTINUATION IS NECESSARY.

PRESCRIBER SIGNATURE _____ **DATE** _____

BY SIGNATURE, THE PRESCRIBER CONFIRMS THE CRITERIA INFORMATION ABOVE IS ACCURATE, VERIFIABLE BY CLIENT RECORDS AND AVAILABLE FOR REVIEW UPON REQUEST.

CONTACT HP ENTERPRISE SERVICES CUSTOMER SERVICE FOR QUESTIONS 1-401-784-8100.

FOR STATE USE ONLY:

APPROVAL: ____ YES ____ NO PRIOR AUTHORIZATION #: _____

EFFECTIVE DATES: FROM: _____ TO _____