



# PRIOR AUTHORIZATION REQUEST FORM Smoking Cessation

DATE OF REQUEST: _____	<u>PROVIDER INFORMATION</u>
<u>MEMBER INFORMATION</u>	NAME _____
NAME _____	NPI # _____
ID # _____	ADDRESS _____
BIRTHDATE _____	_____
<input checked="" type="checkbox"/> <b>PLEASE NOTE:</b> By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.	PHONE # _____ FAX # _____
	CONTACT NAME _____
	PROVIDER SIGNATURE _____

**Drug Requested:**     Chantix     Zyban     Nicotrol     OTC Nicotine Replacement Therapy

Diagnosis: 305.1-Tobacco Abuse     Yes     No     Other: \_\_\_\_\_

**Treatment period (12 week course of treatment, limited to two attempts per year)**  
**Is this the patient's:**

First attempt this year  
 Second attempt, if second attempt, approximate date of last attempt \_\_\_\_\_

**Has patient received (check box):**

YES     NO    Physician counseling  
 YES     NO    Behavior modification evaluation conducted  
 YES     NO    Quit date established  
 YES     NO    Does patient have *any comorbidities (if yes, please list)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**List other medications or therapies patient has tried** \_\_\_\_\_

**Is additional information attached?**     YES     NO

*Refer to the MVP Formularies at [www.mvphealthcare.com](http://www.mvphealthcare.com) for those drugs that require prior authorization or are subject to quantity limits or step therapy.*

<b>FAX THIS REQUEST TO:</b> Commercial <b>1-800-376-6373</b> (HMO, EPO/PPO, Option, Option Family, Healthy NY, Personal Plan, CompCare, ASO)	Medicare Part D <b>1-800-401-0915</b> (Preferred Gold, GoldAnywhere, GoldValue, USA Care, MVP RxCare)
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Effective January 2012