GEORGIA DEPARTMENT OF COMMUNITY HEALTH

Please note: All information below is required to process this request.
Mon-Fri: 8am to 1am Eastern / Sat: 9am to 6pm Eastern

Tobacco Cessation Prior Authorization Request Form

Note: This form must be completed by the physician only. If the following information is NOT filled in completely, correctly, or legibly, the PA process may be delayed. Please complete a form for each member.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Please check all that apply and provide all applicable information.

Member's Diagnosis or History:

❑ Underlying or history of seizure disorder or risk, bulimia or anorexia nervosa

Tobacco Cessation Pharmacotherapy:

If a preferred covered product is being requested (**bupropion [smoking deterrent] SR 150mg generics, Chantix and nicotine gum, lozenge and patch generics**), please list the length of therapy:_____

If a non-preferred covered product is being requested (**Nicotrol Inhaler or Nicotrol Nasal Spray**), please list the preferred product(s) the member has tried, including combination therapy:

Medication:_____ Date(s):_____ Length of therapy:_____
Medication:_____ Date(s):_____ Length of therapy:_____
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Medication:_____ Date(s):_____ Length of therapy:_____

❑ Member will continue smoking/tobacco cessation counseling and will be routinely monitored through face to face counseling while on pharmacotherapy. Smoking/tobacco cessation counseling and routine monitoring is a requirement for coverage of drug therapy.

Physician Signature (required): _____ **Date**:_____

(Stamped signature is not allowed. By signing, the physician confirms the criteria information above is accurate and verifiable in the patient's records).

Physician Office Contact Person: _____ **Phone**: _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: **This request may be denied unless all required information is received.**
For urgent or expedited requests please call 1-866-525-5827.
This form may be used for non-urgent requests and faxed to 1-888-491-9742.