



**Tobacco Cessation Prior Authorization Request From
Fee-for-Service Medicaid/PeachCare for Kids**

PHONE #: 866-525-5827

FAX #: 888-491-9742

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 Last Name [Grid]	MEMBER First Name [Grid]
MEMBER ID number [Grid]	MEMBER Date of Birth AGE: [Grid]
PRESCRIBER Last Name [Grid]	PRESCRIBER First Name [Grid]
PRESCRIBER NPI# [Grid]	
PRESCRIBER Phone [Grid]	PRESCRIBER Fax [Grid]
PRESCRIBER Address [Grid]	

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
- Underlying or history of psychiatric illness

Tobacco Cessation Pharmacotherapy:

Preferred covered products are buproban/bupropion [smoking deterrent] SR 150 mg generics and nicotine gum, lozenge and patch generics.

Medication Requested: _____ Strength: _____ Directions: _____

If a non-preferred covered product is being requested (Chantix, Nicotrol Inhaler, Nicotrol Nasal Spray), please list the preferred product(s) the member has tried: _____

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 patient records).

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

revised 1/23/14

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