AmeriHealth Caritas
Iowa

# AmeriHealth Caritas Iowa
# Request for Prior Authorization

## Nicotine Replacement Therapy

Form applies to IA Health Link and ***hawk-i*** plans.

**Please print – accuracy is important.**

**Quitline Iowa 1-800-784-8669. Fax completed form to 1-855-825-2714.**

| AmeriHealth Caritas Iowa member ID #: | | Patient name: | |
|---|---|---|---|
| Patient address: | | | DOB: |
| Provider NPI: | Prescriber name: | | Phone: |
| Prescriber address: | | | Fax: |
| Pharmacy name: | | | |
| Address: | | | Phone: |
| **Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.** | | | |
| Pharmacy NPI: | | Pharmacy fax: | NDC: |

Prior Authorization is required for over-the-counter nicotine replacement patches, nicotine gum, or nicotine lozenges, and prescription nicotine nasal spray or nicotine inhaler. 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 total combined therapy within a twelve-month period. 5) Patients may receive nicotine replacement patches in combination with one of the oral nicotine replacement products (gum or lozenges). A maximum quantity of 14 nicotine replacement patches and 110 pieces of nicotine gum or 144 nicotine lozenges 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 330 pieces of nicotine gum or 288 nicotine lozenges. Following the first 28 days of therapy, continuation is available only with documentation of ongoing participation in the Quitline Iowa program. 6) Requests for non-preferred nicotine replacement products will be considered after documentation of previous trials and intolerance with a preferred oral and preferred topical nicotine replacement product. A maximum quantity of 168 nicotine inhalers or 40ml nicotine nasal spray may be dispensed with the initial prescription. Subsequent prescription refills will be allowed to be dispensed as a 4 week supply at 336 nicotine inhalers or 80ml of nicotine nasal spray. 7) The 72-hour emergency supply rule does not apply for drugs used for the treatment of smoking cessation.

Please note: AmeriHealth Caritas Iowa uses Iowa Medicaid Enterprise criteria. For complete criteria, please consult http://www.iowamedicaidpdl.com/pa_criteria.

**Preferred**:

Nicotine Patches: ☐ 21mg/24 Hour Patch ☐ 14mg/24 Hour Patch ☐ 7mg/24 Hour Patch

Nicotine Gum: ☐ 2mg ☐ 4mg

Nicotine Lozenge, 144 Count Box: Strength: ☐ 2mg ☐ 4mg

**Non-Preferred**:

☐ Nicotrol Inhaler ☐ Nicotrol Nasal Spray

**If requesting non-preferred product, please include documentation of a preferred oral and topical nicotine replacement product including drug names, strength, exact date ranges and intolerance reasons:**

Diagnosis: Date Referred to Quitline Iowa:

**The Patient has agreed to the following:**

**1)** Volunteered to participate with Quitline Iowa **2)** Quitline Iowa may contact the patient about quitting smoking, local programs, and/or counseling **3)** Quitline Iowa may discuss the patient's use of Quitline with the member's health care provider and/or AmeriHealth Caritas Iowa **4)** All the patient's information will be kept private.

| **Patient's Signature** | **Patient's Phone Number** | **Preferred Language** | **Hearing Impaired/Need TDD** |
|---|---|---|---|

Check www.amerihealthcaritasia.com/Provider to confirm your version of this form.

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### Best times and days for Quitline to call:

☐ 8:00 a.m. to noon
☐ Noon to 4:00 p.m.
☐ 4:00 p.m. to 8:00 p.m.
☐ 8:00 p.m. to midnight
☐ Call at exact time:_______________
☐ Best days to call:_______________
☐ The counselor may leave a message saying he or she is from Quitline Iowa

Outcome (to be faxed to the AmeriHealth Caritas Iowa PA Department at 1-855-825-2714:
☐ Member enrolled in Quitline Iowa Counseling Program Date enrolled: ___________________
☐ Counselors unable to make contact ☐ Other: ___________________

**Attach lab results and other documentation as necessary.**

By signing this document, I attest that the information contained herein is true and accurate to the best of my knowledge and belief. By submitting this form, I acknowledge that I am submitting a request for authorization of health care services, and I agree to abide by and adhere to established federal and Iowa fraud, waste and abuse (FWA) rules and regulations and to remain in compliance with AmeriHealth Caritas Iowa's Program Integrity rules. I further acknowledge that any claim I submit is subject to investigations, review or audit as determined by AmeriHealth Caritas Iowa. I further acknowledge that an authorization is not a guarantee of payment.

| Prescriber signature: (Must match prescriber listed above.) | Date of submission: |
|---|---|

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.