AmeriHealth Caritas
Iowa

# AmeriHealth Caritas Iowa/Quitline Iowa
# Request for Prior Authorization

## Smoking Cessation Therapy – Oral

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

**Please print – accuracy is important.**

**Fax completed form to 1-855-825-2714. Provider Help Desk: 1-855-328-1612.**

| 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 varenicline (Chantix™) or bupropion SR that is FDA approved for smoking cessation. Requests for authorization must include: 1) Diagnosis of nicotine dependence and referral to the Quitline Iowa program for counseling. 2) Confirmation of enrollment and ongoing participation in the Quitline Iowa counseling program is required for approval and continued coverage. 3) Approvals will only be granted for patients eighteen years of age and older. 4) The duration of therapy is initially limited to twelve weeks within a twelve-month period. For patients who have successfully stopped smoking at the end of 12 weeks, an additional course of 12 weeks treatment will be considered with a prior authorization request. The maximum duration of approvable therapy is 24 weeks within a twelve-month period. 5) Requests for varenicline to be used in combination with bupropion SR or nicotine replacement therapy will not be approved. 6) 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 www.iowamedicaidpdl.com/pa_criteria.

(**May check more than one box**)

☐ Chantix™ Starter Pak ☐ Chantix™ 1mg BID ☐ Other: ____________________
☐ Bupropion SR Strength: __________ Dosing Instructions:____________________
☐ PA Renewal

Prescriber signature on this line indicates medical documentation
that the member has stopped smoking after the initial 12 weeks of therapy: ____________________

☐ 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 patient'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: ____________________

Best times and days for Quitline to call:
☐ 8:00 a.m. to noon ☐ 8:00 p.m. to midnight ☐ Noon to 4:00 p.m. ☐ 4:00 p.m. to 8:00 p.m.
☐ Call at exact time:__________________ ☐ Best days to call: ____________________
☐ The counselor may leave a message saying they are 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: ________________

**Please print – accuracy is important.**

**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 attest 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:<br>(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.

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