

Complete Patient and Physician information (PLEASE PRINT)

STEP
1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:
	Tax ID or NPI Number:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

The patient must be enrolled in a smoking cessation program in order for approval to be considered, an example of a free smoking cessation program is the Colorado Quit Line (800-784-8669)

STEP
2

Clinical Consideration	Approved prior authorizations cover one 12 week course of therapy. No more than two 12 week courses of therapy will be approved.
	<p>If this request is for the FIRST 12 week course of therapy:</p> <input type="checkbox"/> Patient 18 years of age or older <input type="checkbox"/> Patient enrolled in Smoking Cessation Program or receiving formal cessation support. <p>Which program is the patient enrolled in? _____</p> <input type="checkbox"/> Patient has not previously been treated with Chantix <input type="checkbox"/> Patient has been treated with Chantix. Length of time: _____
	<p>If this request is for a SECOND 12 week course of therapy: Second 12 weeks is indicated to aid in <i>continued abstinence</i> only. Did patient quit smoking during first 12 weeks, and is pt still abstinent? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description / J Code (required):
	Please attach a copy of the prescription or provide ALL of the information below: Chantix [®] (varenicline) Strength _____ Sig _____ Qty _____ Refills _____
	Please attach all relevant medical records and test results. <p style="text-align: center;">Incomplete forms will not be processed.</p>

I certify that the above is correct and accurate to the best of my knowledge (please sign and date).

STEP 3

Prescriber Signature _____ Date _____

STEP 4

**Fax completed form to the Rocky Mountain Health Plans Pharmacy Help Desk:
970-248-5034**

Name of Person filling out form: _____

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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