

Complete Patient and Physician information (PLEASE PRINT)

STEP 1

Member Name:	Physician Name:
Address:	Address:
Member ID:	Phone #:
Member DOB:	Fax #:

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 (1800-784-8669)

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.
	<input type="checkbox"/> Patient 18 years of age or older <input type="checkbox"/> Patient enrolled in Smoking Cessation Program <input type="checkbox"/> Patient has tried nicotine replacement therapy <i>and</i> bupropion without success, or has a contraindication to these therapies <input type="checkbox"/> Patient has not previously been treated for greater than 12 weeks with Chantix If this request is for a SECOND 12 week course of therapy: Is the patient still smoking? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide rationale for continued use of this medication (2 nd 12 week course of treatment): _____ _____
Supporting Documentation	Diagnosis: ICD-9 Code #/ Description (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. Incomplete forms will not be processed.

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**

Pharmacy Technician initials _____ Date Initiated _____

Confidentiality Notice:

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