

OTC Nicotine Replacement Products

(Commit[®], Nicoderm CQ[®], Nicotrol[®], Nicorette[®], generic patches/gum/lozenges)

Prior Authorization Form



ROCKY MOUNTAIN
HEALTH PLANS[®]

We understand Colorado. We understand you.

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 #:

If Applicable: Pharmacy Name: _____
Pharmacy Phone: _____

Complete the Clinical Assessment:

STEP
2

Diagnosis	<input type="checkbox"/> Pt. enrolled in Smoking Cessation Program	<input type="checkbox"/> Other (please state): _____
Clinical Consideration	<input type="checkbox"/> Pt. is no longer smoking <input type="checkbox"/> Pt. smoking history (Packs Per Day): _____ <i>Approval only applies to OTC nicotine replacement products formulated as a patch, gum or lozenge AND for Medicaid eligible members only.</i> <i>An approval for nicotine patches will not exceed 10 wks of therapy and an approval for gums/lozenges will not exceed 12 wks of therapy.</i> <i>Not more than 2 courses of therapy will be approved in a single calendar year.</i>	
Supporting Documentation	Diagnosis: ICD-9/10 Code #/ Description / J Code (required):	
	Please attach a copy of the prescription or provide ALL of the information below: Name (brand/generic) _____ Strength _____ Sig _____ Qty _____ Refills _____	
	<i>*Please attach all relevant medical records and test results*</i> We will not process incomplete forms. If we do not receive the completed form & all relevant medical records & test results within 10 calendar days of this request, it will be denied.	

STEP
3

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

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:

This facsimile transmission (and/or documents accompanying it) may contain confidential information. This information is intended only for the use of the individual(s) named above. If you have received this transmission in error, or cannot identify the recipient for distribution purposes, please notify us immediately at 970-244-7760. Plans underwritten by Rocky Mountain HMO or Rocky Mountain HealthCare Options.

03/16/10