# Alabama Medicaid Pharmacy
# Smoking Cessation
# Prior Authorization Request Form

**FAX: (800) 748-0116**
**Phone: (800) 748-0130**

**Fax or Mail to**
**Kepro**

**P.O. Box 3570**
**Auburn, AL 36831-3210**

## PATIENT INFORMATION

Patient Name_____ Patient Medicaid #_____

Patient DOB_____ Patient Phone # with area code_____

## PRESCRIBER INFORMATION

Prescriber Name_____ NPI #_____ License #_____

Phone # with area code_____ Fax # with area code_____

Address (optional)_____

**I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Supporting documentation is available in the patient record.**

_____
Prescribing Provider Date

## DRUG/CLINICAL INFORMATION

Drug requested*_____ Strength_____

Drug Code _____ Qty. per month _____ Days' supply_____

Duration of therapy_____ ❒ Initial Request ❒ Renewal Request

A copy of the Department of Public Health's Alabama Tobacco Quitline Patient Referral/Consent Form signed by the recipient must be submitted to the Quitline. **Additionally, a copy of the Consent Form must be submitted along with this Prior Authorization Request form to Kepro for approval.** The form can be found at http://www.alabamapublichealth.gov/tobacco/assets/faxreferralform.pdf

Only one quit attempt will be approved per calendar year.

Plan First Recipients do not require prior approval for smoking cessation products. The Smoking Cessation Prior Authorization Request Form should not be submitted for those recipients.

If the requested drug is a brand name drug with an exact generic equivalent available, the FDA MedWatch Form 3500 must be submitted to Kepro in addition to the PA Request Form.

## DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing Pharmacy_____ NPI #_____

Phone # with area code_____ Fax # with area code_____