Alabama Medicaid Pharmacy
Smoking Cessation
Prior Authorization Request Form

FAX: (800) 748-0116  Phone: (800) 748-0130
Fax or Mail to Health Information Designs
P.O. Box 3210 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 Health Information Designs 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 HID 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 ____________________________