



PRIOR AUTHORIZATION REQUEST FORM
Smoking Cessation*

DATE OF REQUEST: _____
MEMBER INFORMATION
NAME _____
ID # _____
BIRTHDATE _____
PROVIDER INFORMATION
NAME _____
NPI # _____
ADDRESS _____
PHONE # _____ FAX # _____
CONTACT NAME _____
PROVIDER SIGNATURE _____

PLEASE NOTE: By signing this form, you are attesting to the accuracy of the information provided, and that medical record documentation is available if requested.

Drug Requested: [] Chantix® [] Zyban® (twice daily) [] Nicotrol®
Treatment period (12 week course of treatment, limited to two attempts per year)
Is this the patient's:
[] First attempt this year
[] Second attempt, if second attempt, approximate date of last attempt _____
Has patient received (check box):
[] YES [] NO Physician counseling
[] YES [] NO Behavior modification evaluation conducted
[] YES [] NO Quit date established (should be approximately 2 weeks after medication is started)
[] YES [] NO Does patient have any comorbidities (if yes, please list _____)
List other medications or therapies patient has tried _____
Is additional information attached? [] YES [] NO
Refer to the MVP Formulary at www.mvphealthcare.com for those drugs that require prior authorization or are subject to quantity limits or step therapy
* Use this form for members in Schenectady-based products only

FAX THIS REQUEST TO:
Commercial 1-800-376-6373
(HMO, EPO/PPO, Option Child, Healthy NY, Personal Plan, CompCare, ASO)
Medicare Part D 1-800-401-0915
(Preferred Gold, GoldAnywhere, GoldValue, USA Care)
Effective December 1, 2009