

Nicotine Replacement Therapy (NRT) Prior Authorization Form



Patient's Information:

DATE: _____

NAME: _____

DOB: _____

Recipient's Maryland Medicaid Number: _____

SEX: M F

Prescriber's Information:

NAME: _____

NPI #: _____

Phone #: _____

Fax #: _____

Contact Person for this Request:

NAME: _____

Phone#: _____

Fax#: _____

A 90 day trial with either: **one OTC** Nicotine Replacement Therapy (gum, patches, or lozenges), or a **combination of multiple OTC** Nicotine Replacement Therapies has been completed. The trial is required before granting PA approval of Nicotrol[®] Nasal Spray, Nicotrol[®] Inhaler, or Chantix[®] Tablets.

Nicotrol[®] Nasal Spray

- Each actuation of NICOTROL NS delivers a metered 50 microliter spray containing 0.5 mg of nicotine. **2 sprays (One in Each Nostril) = 1 Dose.**
- Start with 1 or 2 doses per hour, which may be increased to a maximum of 5 doses/hr., or 40mg/day (80 sprays).

Directions: 1 spray (0.5mg) into each nostril up to _____ doses per hour.

Nicotrol[®] Inhaler

- Dose is between 6 and 16 cartridges a day. **Maximum 16 cartridges/day**

Directions: Inhale _____ cartridges/day prn

Chantix[®]

Dose/Directions (choose one):

- Start:** Titration 0.5 mg po daily x 3 days, then 0.5 mg po bid x 4 days
- Continuation:** 1.0 mg po BID
- Continuation:** 0.5 mg po daily (renal impairment dosing)
- Other:** _____

Notes:

- 1) Prior Bupropion treatment will not be considered for approval of Chantix or Nicotrol.
- 2) E-Cigarette use will not be considered for approval of Chantix or Nicotrol.

I certify that the above information is accurate and will be made available for audit if requested.

Prescriber's Signature _____

Date _____

Fax this completed form to 866-440-9345. Incomplete forms will not be reviewed.