Maryland Medicaid
Pharmacy Program
Fax: (866) 440-9345
Phone: (800) 932-3918

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.