Alabama Medicaid Pharmacy
Smoking Cessation Request Form

FAX: (800) 748-0116 | **Fax or Mail to** | **P.O. Box 3210**

Phone: (800) 748-0130 | **Health Information Designs** | **Auburn, AL 36832-3210**

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 am the prescribing provider. ❒ Yes ❒ No

I am the maternity care coordinator assigned to the recipient indicated above. ❒ Yes ❒ No

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 or Maternity Care Coordinator Signature Date

DRUG/CLINICAL INFORMATION

Drug requested* _____ Strength _____

Drug Code _____ Qty. per month _____ Days supply _____

Duration of therapy _____ ❒ Initial Request ❒ Renewal Request

*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.

Is the recipient currently pregnant or within 60 day post partum period? ❒ Yes ❒ No

Is the recipient currently enrolled in the Quitline program through the Department of Public Health and has the recipient completed a counseling session with a Quitline representative in the last 30 days? ❒ Yes ❒ No

DISPENSING PHARMACY INFORMATION

May Be Completed by Pharmacy

Dispensing Pharmacy _____ NPI # _____

Phone # with area code _____ Fax # with area code _____