The Alabama Tobacco Quitline and Alabama Medicaid Agency: A Partnership

1.800.QUITNOW

QUITNOWALABAMA.COM

1-800-784-8669

Building The Relationship

Setting The Stage

Quitline Workgroup
ROI document
CMS memo
Medicaid Learning Community

Making It Work

MOU with Medicaid
Quitline NRT protocol change
Promotion

Medicaid Forms For Cessation Medication Approval

FAX REFERRAL FORM

1.800.QUITNOW
QUITNOWALABAMA.COM
1-800-784-8669

To be contacted by **Quit Now Alabama** fax this completed form to: **1-800-261-6259**

REFERRING ORGANIZATION: Complete this section

Organization/ Practice ____ Contact Name ____
Clinic/Hosp/Dept ____ E-mail ____
Address ____ Phone ( ) -
City/State/Zip ____
Fax ( ) - *If you do not wish to receive fax-back updates on patient referrals enter NA for fax number.*
Referrer Signature ____ Date ____

Are you a Medical Provider: ☐ Yes ☐ No *If Yes, please provide credentials:* ____
Please Check: ☐ Participant agreed to be referred to **Quit Now Alabama.**

PROVIDER: Complete this section (only necessary if one of the below conditions exists)

Does patient have any of the following conditions: ☐ Pregnant/Breastfeeding ☐ Uncontrolled high blood pressure ☐ Heart disease ☐ Stroke

If yes, please sign to authorize **Quit Now Alabama** to send the patient free, over-the-counter nicotine replacement therapy if available. If provider does not sign and the patient has any of the above listed conditions, **Quit Now Alabama** cannot dispense medication.

Provider Signature ____ Date ____

PATIENT: Complete this section

____ *Initial* Yes, I am ready to quit and ask that a coach call me. I understand that **Quit Now Alabama** may inform the referring party about my participation.

Best times to call: ☐Morning ☐Afternoon ☐Evening ☐Weekend
May we leave a message: ☐Yes ☐No
Date of Birth? / / Gender ☐Male ☐Female
Patient Name (Last) ____ (First) ____
Address ____ City ____ State ____
Zip Code ____ E-mail ____
Phone #1 ( ) - Phone #2 ( ) -
Language ☐English ☐Spanish ☐Other ____

Patient Signature ____ Date ____
If no patient signature available: ☐ Check to Verify Patient Consent is on File.

The Quit Now Alabama Program will call you within 24 hours of receiving this referral. The call will come from "800-784-8669". In addition the Quitline is open 7 days a week.

FOR QUITLINE REFERRAL PLEASE FAX COMPLETED FORM TO: 1-800-261-6259

For additional forms visit www.adph.org/tobacco

Alabama Medicaid Pharmacy
Smoking Cessation
Prior Authorization 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 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.adph.org/tobacco/assets/FaxReferralForm2014.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.

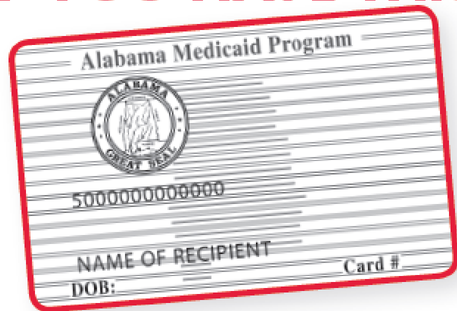
If the requested drug is a brand name drug with an exact generic equivalent available, the FDA MedWatch Form 3500 must be submitted to HID in addition to the PA Request Form.

DISPENSING PHARMACY INFORMATION
May Be Completed by Pharmacy

Dispensing Pharmacy ____ NPI # ____
Phone # with area code ____ Fax # with area code ____

Promoting the benefit

IF YOU HAVE THIS,



QUITTING SMOKING IS EASIER THAN YOU THINK.

TALK TO YOUR DOCTOR OR CALL

1.800.QUITNOW

QUITNOWALABAMA.COM

1-800-784-8669

MEDICAID NOW COVERS TOBACCO CESSATION MEDICATIONS!

LEARN MORE! VISIT QUITNOWALABAMA.COM

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1-800-784-8669

Lessons Learned

Medicaid is unique.

Relationships matter.

Expect barriers.

Keep promoting benefit.

Contact Information

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Tobacco Prevention & Control Branch
Alabama Department of Public Health

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