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

REFERRING ORGANIZATION: Complete this section
Organization: ____________________________
Practice: ______________________________
Clinic/Hosp/Dept: ________________________
E-mail: ________________________________
Address: ______________________________
Phone ( ): ______________________________
Fax ( ): ________________________________

Are you a Medical Provider: [ ] Yes [ ] No
If Yes, please provide credentials: _________
Please Check: [ ] Participant agreed to be referred to Quit Now Alabama

If you do not wish to receive follow-up updates on patient referrals enter NA for fax number.

Provider Signature
Referrer Signature

REFERRAL FORM: 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.

PATIENT: Complete this section

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.

Initial: ____________________________

Best times to call: [ ] Morning [ ] Afternoon [ ] Evening [ ] Weekend

May we leave a message: [ ] Yes [ ] No

Date of Birth: / / Gender [ ] Male [ ] Female

Patient Name (First): ____________________________

Address: ____________________________

City: ____________________________

State: ____________________________

Zip Code: ____________________________

Phone #1 ( ): ____________________________

Phone #2 ( ): ____________________________

Language: [ ] English [ ] Spanish [ ] Other

For additional forms visit www.adph.org/tobacco

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

Alabama Medicaid Pharmacy Smoking Cessation Prior Authorization Request Form

FAX: (800) 748-0115
Fax or Mail to: Health Information Designs

Patient Name: ____________________________

Patient DOB: ____________________________

Patient Phone #: ____________________________

Patient Medicaid #: ____________________________

PREScriber INFORMATION

Prescriber Name: ____________________________

NPI #: ____________________________

License #: ____________________________

Address: ____________________________

Phone #: ____________________________

Fax #: ____________________________

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.

Drug requested: ____________________________

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 (MO USE D) 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 NPI #: ____________________________

Dispensing Pharmacy: ____________________________

Phone #: ____________________________

Fax #: ____________________________

Alabama Medicaid Agency www.medicaid.alabama.gov
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
1.800.QUITNOW
QUITNOWALABAMA.COM
1-800-784-8669
Lessons Learned

Medicaid is unique.

Relationships matter.

Expect barriers.

Keep promoting benefit.
Contact Information

Julie Hare
Director, Public Information Unit
Tobacco Prevention & Control Branch
Alabama Department of Public Health

Phone: 334/206-3830

Julie.Hare@adph.state.al.us