

Strictly Confidential
SMOKING CESSATION MEDICATION Prior Authorization Form

Fax completed form to 1-902-481-7114

**Or Mail to: MHCSI, 201 Brownlow Avenue, Unit 20
Dartmouth, NS B3B 1W2**

This form must be completed **IN FULL** and submitted to MHCSI to permit authorization for coverage of a smoking cessation medication on your employer-sponsored drug plan. Coverage will be granted if criteria are met, and smoking cessation medications are covered by your plan. Approvals may be subject to quantity or dollar limits as per plan design.

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____
(PLEASE PRINT)

ADDRESS: _____ (CITY)
(STREET/MAILBOX)
(PROVINCE) (POSTAL CODE)

MHCSI CARD NUMBER: _____ / _____
(GROUP #) (CERTIFICATE OR CLIENT#)

I hereby authorize my physician/nurse practitioner and/or pharmacist to provide the information necessary to complete this form on my behalf for request of coverage of medication for erectile dysfunction by my drug plan.

SIGNATURE: _____ DATE: _____

CRITERIA FOR COVERAGE

Patients are eligible for coverage of approved smoking cessation medications if they meet the following criteria:

1. Have been assessed by the prescribing physician and/or pharmacist for the appropriateness of the smoking cessation medication(s) being requested for this patient on a case-by-case basis, considering level of smoking (i.e. degree of nicotine dependence), past quit attempts (and methods/products used), and concurrent medication(s) and medical condition(s).
2. Provide evidence of previous quit attempts (if any) and methods used/duration of abstinence.
3. Recommended concurrent participation in a recognized and personalized smoking cessation behavioral management program (where appropriate/available).

CONDITIONS OF APPROVAL

Champix: Pursuant to a physician's/nurse practitioner's prescription in conjunction with smoking-cessation counselling. Dosed as per product monograph for an approval of up to a 12-week supply (dispensed in monthly allotments). A possible extension to the initial approval will be considered on a case-by-case basis with resubmission of the Non-Formulary Request form with updated clinical information confirming **successful** smoking cessation during the initial 12-week treatment. Currently, it is NOT recommended to use Champix in combination with nicotine replacement therapy.

Zyban (bupropion): Pursuant to a physician's/nurse practitioner's prescription. Dosed as per product monograph for an initial approval of up to a 12 week supply (dispensed in monthly allotments). Extensions to the approval will be considered on a case-by-case basis with resubmission of the Non-Formulary Request form with updated clinical information.

***OTC products-Nicotine Patches, Gum, and Nicorette Inhaler:** Pursuant to a physician's/nurse practitioner's prescription or pharmacist's order. Dosed as per product monograph for an initial approval of up to a 12- week supply. Extension to the approval will be considered on a case-by-case basis with resubmission of the Non-Formulary Request form with updated clinical information.

Initial quantities approved: Patches – 12 x 7 patches
Nicotine Gum: 30-105 pack size
Nicorette Inhaler: 6-42 pack size

***Some groups which do cover smoking cessation will only cover Zyban or Champix, no OTC products**

Continued on next page

**TO BE COMPLETED BY THE PHYSICIAN/NURSE PRACTITIONER (NP)
and/or PHARMACIST IN CONSULTATION WITH THE PHYSICIAN/NURSE PRACTITIONER**

Dear Doctor/Nurse Practitioner/Pharmacist: We appreciate you providing information on this patient's medical condition and medication history which is required by the drug plan sponsor for authorization of claims for smoking cessation medications. Please complete the following sections of this form IN FULL. Any costs incurred in the completion of this form are the responsibility of the patient.

Medication Requested:-generic brand may be used where available

Drug Name	Strength	DIN
Zyban (bupropion)	<input type="checkbox"/> 150 mg	<input type="checkbox"/> 02238441
Nicotine Patches Nicoderm Habitrol	<input type="checkbox"/> 21mg <input type="checkbox"/> 14mg <input type="checkbox"/> 7mg	<input type="checkbox"/> 02093146 <input type="checkbox"/> 02093138 <input type="checkbox"/> 02093111 <input type="checkbox"/> 01943073 <input type="checkbox"/> 01943065 <input type="checkbox"/> 01943057
Nicorette Gum	<input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg	<input type="checkbox"/> 02091941 <input type="checkbox"/> 02091933
Nicorette Inhaler	<input type="checkbox"/> 10mg/4mg	<input type="checkbox"/> 02241742
Champix (varenicline tartrate)	<input type="checkbox"/> 0.5mg <input type="checkbox"/> 1mg <input type="checkbox"/> starter pack	<input type="checkbox"/> 02291177 <input type="checkbox"/> 02291185 <input type="checkbox"/> 02298309
Please specify dosing schedule:		
Is this request for a <input type="checkbox"/> first time quit attempt, <input type="checkbox"/> continuation or <input type="checkbox"/> re-trial of smoking cessation therapy?		

INFORMATION SUPPORTING REQUIREMENT FOR THIS MEDICATION

Patient/Treatment Parameters & Description		
Concurrent Medical Conditions <i>(check any/all that apply)</i>	<input type="checkbox"/> None <input type="checkbox"/> Cardiovascular Disease, <i>please specify:</i> <input type="checkbox"/> Cerebrovascular Disease, <i>please specify:</i> <input type="checkbox"/> Diabetes <input type="checkbox"/> Gastrointestinal Disease, <i>please specify:</i> <input type="checkbox"/> Asthma/ COPD <input type="checkbox"/> Cancer, <i>please specify:</i> <input type="checkbox"/> Depression <input type="checkbox"/> Other, <i>please specify:</i>	
History of past quit attempts?	<input type="checkbox"/> No <input type="checkbox"/> Yes <i>(If Yes, please provide details thereof, including number of and response to previous attempts)</i>	
Planned concurrent personalized smoking cessation behavioral management support programming <i>(check any/all that apply)</i>	<input type="checkbox"/> Physician/NP-based monitoring program <input type="checkbox"/> Pharmacist-based monitoring program <input type="checkbox"/> Employer-sponsored Employee Assistance Program (EAP) <input type="checkbox"/> Manufacturer's Support Program (e.g. Zyban®Net) <input type="checkbox"/> Commercial programs (e.g. Lung Association or private program) <i>Please specify:</i> <input type="checkbox"/> No concurrent behavioral support programming planned	
Physician/NP Name/Signature: /	Phone:	Date:
Pharmacist Name/Signature: /	Store # & Location/ Phone # : &	Date:
OFFICE USE ONLY		
Approval <input type="checkbox"/> Accepted <input type="checkbox"/> Declined	Date	Quantity
	Approved by	and/or End date
Extension possible	<input type="checkbox"/> Yes <input type="checkbox"/> No	