

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM  
**Chantix (varenicline)**

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_  
Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Phone#: \_\_\_\_\_ Ext. and opt. \_\_\_\_\_ Fax# \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

All information to be legible, complete and correct or form will be returned

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**PRIOR AUTHORIZATION MAY BE OBTAINED WITH A TELEPHONE CALL FROM THE PRESCRIBER OR PHARMACY TO 1-800-662-9651 OR BY FAXING DOCUMENTATION OR A LETTER OF MEDICAL NECESSITY TO (801)536-0477**

**CRITERIA:**

- Minimum age: 18 years old.
- Covered for a diagnosis of nicotine dependence for 24 weeks per calendar year.

**AUTHORIZATION:**

24 weeks per calendar year.

**RE-AUTHORIZATION:**

Same as initial.

7/14/2009