

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

Patient name: \_\_\_\_\_ Medicaid ID #: \_\_\_\_\_  
Prescriber Name: \_\_\_\_\_ Prescriber NPI#: \_\_\_\_\_ Contact person: \_\_\_\_\_  
Prescriber Phone#: \_\_\_\_\_ Extension/Option: \_\_\_\_\_ Fax#: \_\_\_\_\_  
Pharmacy: \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_  
Requested Medication: \_\_\_\_\_ Strength: \_\_\_\_\_ Frequency/Day: \_\_\_\_\_

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

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**FAX DOCUMENTATION OR A LETTER OF MEDICAL NECESSITY  
TO 855-828-4992 note the new fax number**

**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.

9/13/2010