

**Department for Medicaid Services
Tobacco Cessation Referral Form**

Provider Information (to be completed by the provider)

Provider National Provider Identifier (NPI): _____
Provider Name: _____
Provider Fax #: _____ Provider Phone #: _____
Provider Email Address (if available): _____

Recipient Information (to be completed by the recipient)

Recipient ID: _____ Date of Birth: _____
Name: _____ Gender: Male Female
Pregnant? Yes No
Street Address: _____
Apt/Bldg#: _____
City: _____ County: _____ Zip Code: _____
Primary Telephone#: _____ Secondary Telephone#: _____
Date of Visit: _____

Prescriber: Please refer to FDA guidelines regarding the use of Chantix™ in pregnant women.

Tobacco Cessation Medication Choice(s) Prescribed for the Recipient [to be completed by the provider]

- Nicotine replacement therapy (NRT) gum _____ NRT patch _____
 NRT lozenge _____ NRT inhaler _____
 NRT spray _____ Bupropion Varenicline

Prescription amount must be for a one-month supply with two subsequent one-month refills

Tobacco Cessation Support Program Chosen for the Recipient (to be completed by the provider)

- The Cooper/Clayton Method Freedom from Smoking® Online
 Kentucky's Tobacco Quitline Chantix™
 Other Program (**Must be Prior Approved** by the Department): _____
 Recipient does not require support program
 Support program attendance would create hardship for recipient (provider: please explain: _____

_____)

IMPORTANT: If recommending a program not listed on this form, the provider **MUST** request approval from the Department for Medicaid Services (DMS) **PRIOR** to recommending the program; otherwise, the department shall not reimburse for any tobacco cessation medication prescribed in conjunction with the unapproved program. To request DMS approval, please fax this completed form to (502) 564-0223 and write "tobacco cessation program approval request" at the top of this form or on a separate cover page.

Tobacco Cessation Program Contact Person: _____
Contact Person Phone Number #: _____
Contact Person Email Address (if available): _____
Provider Signature: _____ Date: _____

Recipient Commitment (to be completed by the recipient)

What kind of tobacco do you use? Cigarette Smokeless Tobacco
Cigar Pipe

I am ready to quit using tobacco and want to complete a tobacco cessation program

I understand that to get medication to help me stop using tobacco, I have to participate in the tobacco cessation support program chosen for me by my provider. If my provider has written me a prescription for medication to help me stop using tobacco, I can get the first month's supply by signing this form. Before I can get my medication refilled, I must tell Medicaid that I will continue to go to the support program chosen by my provider. To do this, I can:

- Call Medicaid at 502-564-9444, or
- Write to Tobacco Cessation Program, Kentucky Medicaid, 275 East Main Street, 6C-C, Frankfort, KY 40601 or
- Send a fax to 502-564-0223

I understand that I must, if asked, give an update on my progress or lack of progress in quitting tobacco.

Recipient Signature: _____

Date: _____

Provider FAX Instructions

Please fax the completed and signed form to (502) 564-0223 and give a copy of the completed and signed form to the recipient

If you have any questions, please contact the Department for Medicaid Services, Division of Medical Management at (502) 564-9444 and mention "tobacco cessation referral" as the subject of your call

PROVIDERS NOTE: A copy of this form must be on file with Kentucky Medicaid before your claim for the tobacco cessation assessment will be paid.