FAX-TO-QUIT REFERRAL FORM

Date _____

COLORADO QuitLine™ Be tobacco free

Use this form to refer patients who are ready to quit tobacco in the next 30 days to the Colorado QuitLine.

PROVIDER(S): Complete this section

Provider name _____ Contact name _____

Clinic/Hosp/Dept _____ E-mail _____

Address _____ Phone ( ) –

City/State/Zip _____ Fax ( ) –

PLEASE INDICATE IF THE PATIENT HAS MEDICAID: ☐YES ☐NO

If yes, and you are prescribing tobacco cessation medication, please complete the Medicaid prior-authorization form on the back of this form and provide patient with a prescription. All FDA-approved tobacco cessation medications are available.

Does patient have any of the following conditions?

☐pregnant ☐uncontrolled high blood pressure ☐heart disease

☐**YES**, I authorize the QuitLine to send the patient over-the-counter nicotine replacement therapy.

Provider signature _____

A provider signature is required to authorize the QuitLine to dispense nicotine replacement therapy for patients with any of the above conditions.

Comments _____

PATIENT: Complete this section

_____ *Initial* Yes, I am ready to quit and ask that a QuitLine coach call me. I understand that the Colorado QuitLine will inform my provider about my participation.

Best times to call? ☐morning ☐afternoon ☐evening ☐weekend

May we leave a message? ☐Yes ☐No

Are you hearing impaired and need assistance? ☐Yes ☐No

Insurance? ☐Yes ☐No

Insurance carrier: _____

Member ID: _____

Medicaid? ☐Yes ☐No

Date of birth: / / Gender ☐M ☐F

Patient name (Last) (First) _____

Address _____ City _____ CO

Zip code _____ E-mail _____

Phone #1 ( ) – Phone #2 ( ) –

Language ☐English ☐Spanish ☐Other _____

Patient signature _____ Date _____

PLEASE FAX THIS PATIENT FAX REFERRAL FORM TO: 1-800-261-6259

Or mail to: Colorado QuitLine, National Jewish Health, 1400 Jackson St., M305, Denver, CO 80206

COLORADO MEDICAID PHARMACY
PRIOR AUTHORIZATION FORM

21442

Request Date / /

PATIENT INFORMATION

Patient's Medicaid ID Number

Patient's Date of Birth / /

Patient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City **State** **Zip Code** -

Prescriber Phone: - -

Prescriber Fax: - -

Prescriber NPI #

Prescriber DEA # -

Drug Requested:

Strength _____ **Quantity** _____ **Frequency of Dosing** _____

Diagnosis:_____ **Method of Diagnosis (if applicable)**_____

Failed Medications:_____

Contraindications / Allergies:_____

Current Medications:_____

Relevant Lab Values:_____ **Date of Lab Results**_____

Medical Justification:_____

Where will medication be administered? Circle one:

Client's home, Long-term care facility, Dr's office, Dialysis unit or Hospital

Requests that do not include the required information will experience a delay in the approval process. To expedite this process, please review the prior authorization criteria in Appendix P at http://www.colorado.gov/cs/Satellite/HCPF/HCPF/1201542571132.

Signature of Prescriber_____ **Date** / /

By signature, the Prescriber confirms the criteria information above is accurate and verifiable in patient records

FAX TO: COLORADO Medicaid Prior Authorizations
Fax: (888)-772-9696
PA HELPDESK: (800) 365 - 4944

21442

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