Updated: 09/2019
DMMA Approved: 09/2019

Request for Prior Authorization for Chantix (varenicline)
Website Form – www.highmarkhealthoptions.com
Submit request via: Fax - 1-855-476-4158

All requests for Chantix (varenicline) require a Prior Authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Chantix (varenicline) Prior Authorization Criteria:

Coverage may be provided with a diagnosis of the need for smoking cessation treatment and the following criteria is met:

- Member is 18 years of age or older
- The requested dose and frequency is in accordance with FDA-approved labeling, nationally recognized compendia, and/or evidence-based practice guidelines
- Member has tried and failed or had an intolerance to a combination of 2 nicotine replacement therapies (NRTs). Dosage forms covered include an oral inhalation, intranasal inhalation, transdermal patch, oral gum, and oral lozenge

- **Initial Duration of Approval:** 6 months.

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.

Highmark Delaware Health Options

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Chantix® (varenicline) PRIOR AUTHORIZATION FORM

Please complete and fax all requested information below including ***any progress notes, laboratory test results, or chart documentation*** as applicable to Health Options Pharmacy Services. **FAX:** 1-855-476-4158
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE**: 1-844-325-6251

PROVIDER INFORMATION

Requesting Physician:	NPI:
Physician Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

MEMBER INFORMATION

Member Name:	
Health Options ID:	DOB:

DRUG INFORMATION

Product: ☐ Chantix Starting Month Box ☐ Chantix 0.5 mg tablets
☐ Chantix Continuing Month Box ☐ Chantix 1 mg tablets

Frequency:	Duration:
Is the member currently receiving requested medication? ☐ Yes ☐ No	Date Medication Initiated:

Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? ☐ Yes ☐ No

MEDICAL HISTORY

Diagnosis:_____
Co-morbid diagnosis: _____

Has the member tried and failed or had an intolerance to a combination of 2 nicotine replacement therapies? ☐ Yes ☐ No
If yes, please provide information in previous therapy section below.

PREVIOUS THERAPY

Drug Name	Strength/Frequency	Dates of Therapy	Status (Discontinued & Why or Current)

SUPPORTING INFORMATION OR CLINICAL RATIONALE

Prescribing Physician Signature	Date