Updated: 01/2019
PARP Approved: 01/2019

Prior Authorization Criteria

Chantix (varenicline)

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

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
- Member has tried and failed or had an intolerance or contraindication to bupropion
- **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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.

Gateway Health

Updated: 01/2019
PARP Approved: 01/2019

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 Gateway Health℠ Pharmacy Services. **FAX:** (888) 245-2049
If needed, you may call to speak to a Pharmacy Services Representative.
PHONE: (800) 392-1147 Monday through Friday 8:30am to 5:00pm

PROVIDER INFORMATION

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

MEMBER INFORMATION

Member Name:	DOB:
Gateway ID:	Member weight: _____pounds or _____kg

REQUESTED DRUG INFORMATION

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

Billing Information

This medication will be billed: ☐ at a pharmacy **OR**
☐ medically (if medically please provide a JCODE:_____

Place of Service: ☐ Hospital ☐ Provider's office ☐ Member's home ☐ Other

Place of Service Information

Name:	NPI:
Address:	Phone:

MEDICAL HISTORY (Complete for ALL requests)

Diagnosis: ☐ Smoking Cessation ☐ Other: _____ ICD-10 Code: _____

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.

Has the member tried and failed bupropion? ☐ Yes ☐ No **If yes**, please provide information in previous therapy section below.

CURRENT or PREVIOUS THERAPY

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

SUPPORTING INFORMATION or CLINICAL RATIONALE

Prescribing Provider Signature	Date