Delaware Medicaid and Medical Assistance
Request for Prior Authorization - Nicotine Replacement Therapies
Submit request via: Fax – 1-302-454-0224 or Website – WWW.DMAP.STATE.DE.US

(patches, gum, nasal spray, inhalers, tablets, lozenges)
New products with this classification will automatically require the same documentation.

Nicotine replacement products aim to replace nicotine of cigarettes in order to reduce withdrawal symptoms associated with smoking cessation.

Covered Conditions

- Aid in cessation of tobacco usage

General Requirements

- FDA approved dosage and duration
- Must be ≥ 18 years of age
- Must be enrolled in a cessation program or have access to counseling with enrollment occurring at least 2 weeks prior to “quit date”
- Limit to three quit attempts per 12 months
- Limit of one treatment modality per quit attempt. Concurrent use of products will not be covered.
- Coverage of inhaler requires documented prior attempts with gum, patches, and nasal spray, and lozenges
- Coverage of Varenicline (Chantix) tablets will require the failure of a nicotine agonist. Chantix requests with no documented failure of a first line agent will be approved with a relevant co-morbid diagnosis or medical rationale for avoiding first line therapies.
- Approvals will be in a two-fold duration, initially for 3 months, then a reevaluation form will be needed for an additional 3 month approval.

Treatment Modalities	Daily Max Dose	Duration per attempt	Max Annual attempt
Nicotine Gum	<24 pieces	12 Weeks	3
Nicotine Patch	1 patch	12 Weeks	3
Nicotine Nasal Spray	< 40 sprays	6 months	2
Nicotine Lozenges	< 12 lozenges	12 Weeks	3
Nicotine Inhaler	< 16 cartridges	6 months	2
Varenicline	2 tablets	3-6 months	2

Authorization

Client Name ___________________________Medicaid Number_______________________DOB ___________

Practitioner Name _____________________________________Provider Number________________

Office Phone Number___________________________________Office Fax Number______________________

Diagnosis ____Co-morbid Diagnosis____________________

Proposed Regimen: Gum____ Patch____ Nasal Spray___ Lozenges___ Inhaler___ Tablet ______

Date of Last Quit Attempt (if applicable) ___________________Product ______________________________

Cessation Program Information____

Date _________________Additional Comments: