Nicotine Replacement Therapy (NRT)
Prior Authorization Form
Incomplete forms will not be reviewed

Maryland Medicaid Pharmacy Program
Fax: (866) 440-9345
Phone: (800) 932-3918

Date (MM/DD/YYYY): _____

Patient Information

Name: _____ DOB (MM/DD/YYYY): _____

Medicaid Assistance Number: _____ Sex: ❑ M ❑ F Height: _____ Weight: _____

Prescriber Information

Name: _____ NPI: _____

Phone: _____ Fax: _____

Contact Person for this request:

Name: _____ Phone: _____ Fax: _____

❑ **A 90-day trial** with either: **One (1) OTC** Nicotine Replacement Therapy (gum, patches, or lozenges), **OR** a **combination of multiple OTC** Nicotine Replacement Therapies has been completed. The trial is required before granting PA approval of Nicotrol® Nasal Spray or Nicotrol® Inhaler.

Nicotrol® Nasal Spray
➢ Each actuation of NICOTROL NS delivers a metered 50 microliter spray containing 0.5 mg of nicotine. **2 sprays (One in Each Nostril) = 1 Dose.**
➢ Start with 1 or 2 doses per hour, which may be increased to a maximum of 5 doses/hr., or 40mg/day (80 sprays).
❑ **Directions:** 1 spray (0.5mg) into each nostril up to _____doses per hour.

Nicotrol® Inhaler
➢ Dose is between 6 and 16 cartridges a day. **Maximum 16 cartridges/day**
❑ **Directions:** Inhale _____cartridges/day prn

Notes:

1. Patient Prior Bupropion treatment will not be considered for approval of Nicotrol.
2. Patient E-Cigarette use will not be considered for approval of Nicotrol.

I attest that:

❑ The benefits of the treatment outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge

❑ The MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature for all purposes and shall have the same force and effect as an original.

Prescriber's Signature: _____ Date (MM/DD/YYYY): _____