FAX-TO-QUIT	REFERRAL	FORM
Date		



this

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

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 com	plete the Medicaid prior-authorization form on the back of
form and provide patient with a prescription. All FDA-approved tobacco of	essation medications are available.
Does patient have any of the following conditions?	
\square pregnant \square uncontrolled high blood pressure \square heart disease	
\square YES, I authorize the QuitLine to send the patient over-the-counter nice	otine replacement therapy.
Provider signature	
A provider signature is required to authorize the QuitLine to dispense nic of the above conditions.	cotine replacement therapy for patients with any
Comments	
PATIENT: Complete this section	
Yes, I am ready to quit and ask that a QuitLine coach call me. I my provider about my participation.	understand that the Colorado QuitLine will inform
Best times to call? \square morning \square afternoon \square evening \square weekend	Insurance? Yes No
May we leave a message? ☐ Yes ☐ No	Insurance carrier:
Are you hearing impaired and need assistance? ☐ Yes ☐ No	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	
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

	Reques	t Da	te						
21442		/			/				
Patient's Medicaid ID Number PATIENT INFORMATION	Patient	_ 'e D:	ato c	of Rir	th				=
TATIENT IN ORMATION] <i>[</i>			/				
Dationals Full Name] /			1				
Patient's Full Name		Π	П						
Prescriber's Full Name PRESCRIBER INFORMATION									_
Prescriber Street Address									_
City State	Zip Cod	de							_
					-				
Prescriber Phone: Prescrib	ber Fax:								
	-				-				
Prescriber NPI #	Prescri	ber l	DEA	#					
] -							
Drug Requested:									=
StrengthQuantity 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 .								-	
	Date	٦.			- ر ا	_			
Signature of Prescriber	rate and	∫ / d vei	rifial	l ble in		 tient	rece	ords	

FAX TO: COLORADO Medicaid Prior Authorizations

Fax: (888)-772-9696 PA HELPDESK: (800) 365 - 4944





