

# Bravo Health

Coverage Review / Prior Authorization Request Form  
**Smoking Cessation Medications**  
Chantix, Zyban, and Nicotine Replacement Products



Patient Information		Prescriber Information	
Member Name:		Prescriber Name:	
Bravo ID #		Prescriber Specialty:	
DOB:		Prescriber Address:	
Address:			
		Office Phone#:	
Home Phone:		Office Fax #:	
		Contact Person:	
Diagnosis and Medication Requested			
Medication Requested (dosage, frequency):		Qty:	
Prescribing Diagnosis:	ICD9 Code	Date Therapy Initiated:	
Clinical Criteria			
<b>Please answer the following questions:</b>			
1. Is the member enrolled in a behavioral support/ modification program (e.g., manufacturer/ organizational affiliated program, community based health or health professional.)?			
Yes, please explain:			
No			
2. Is the member currently taking Bupropion (Zyban, Wellbutrin) or utilizing any nicotine replacement therapy? Have they tried any of these previously? [Note: failure to explain the nature of the intolerance could result in the denial of this request.]			
Yes, please explain:			
No			
Additional Comments/Explanation:			
Request for Expedited Review			
<input type="checkbox"/> <b>REQUEST FOR EXPEDITED REVIEW [24 HOURS]</b> <b>BY CHECKING THIS BOX AND SIGNING BELOW, I CERTIFY THAT APPLYING THE 72 HOUR STANDARD REVIEW TIME FRAME MAY SERIOUSLY JEOPARDIZE THE LIFE OR HEALTH OF THE MEMBER OR THE MEMBER'S ABILITY TO REGAIN MAXIMUM FUNCTION</b>			

Prescriber's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Fax back to: 866-464-0709 For info call: 877-813-5595  
For additional Prior Authorization forms, go to <http://www.bravohealth.com/providers.aspx>