FAX-TO-QUIT REFERRAL FORM

Date ____________________

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

PROVIDER(S): Complete this section

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 complete the Medicaid prior-authorization form on the back of this form and provide patient with a prescription. All FDA-approved tobacco cessation medications are available.

Does patient have any of the following conditions?

☐pregnant ☐uncontrolled high blood pressure ☐heart disease

☐**YES**, I authorize the QuitLine to send the patient over-the-counter nicotine replacement therapy.

Provider signature ____________________

A provider signature is required to authorize the QuitLine to dispense nicotine replacement therapy for patients with any of the above conditions.

Comments ____________________

PATIENT: Complete this section

_____ *Initial* Sí, estoy listo para dejar de fumar y pido que un orientador de QuitLine me llame. Comprendo que Colorado QuitLine le informará a mi proveedor de salud sobre mi participación.

Indique la mejor hora para llamarle ☐mañana ☐tarde ☐noche ☐fin de semana

¿Podemos dejar un mensaje? ☐Sí ☐No

¿Padece deficiencia auditiva (problemas con su sentido de oír) y necesita ayuda? ☐Sí ☐No

¿Tiene seguro medico? ☐Sí ☐No

Compañía de seguros medico: ____________________

No. de identificación de miembro: ____________________

¿Medicaid? ☐Sí ☐No

Fecha de nacimiento: / / Sexo ☐M ☐F

Nombre del paciente: ____________________

Dirección ____________________ Ciudad ____________________ CO

Código postal ____________________ E-mail ____________________

Teléfono #1 ( ) – Teléfono #2 ( ) –

Idioma ☐inglés ☐español ☐otro ____________________

Firma de paciente: ____________________ Fecha: ____________________

POR FAVOR ENVÍE ESTE FORMULARIO DE REFERENCIA DE PACIENTE VÍA FAX AL: 1-800-261-6259 O ENVÍELO POR CORREO A:
Colorado QuitLine, National Jewish Health, 1400 Jackson St., M305, Denver, CO 80206

Confidentiality Notice: This facsimile contains confidential information. If you have received this in error, please notify the sender immediately by telephone and confidentially dispose of the material. Do not review, disclose, copy or distribute.

COLORADO MEDICAID PHARMACY PRIOR AUTHORIZATION FORM

Request Date ___ / ___ / ______

PATIENT INFORMATION

Patient's Medicaid ID Number

Patient's Date of Birth ___ / ___ / ______

Patient's Full Name

PRESCRIBER INFORMATION

Prescriber's Full Name

Prescriber Street Address

City

State

Zip Code ______ - ____

Prescriber Phone: ___ - ___ - ____

Prescriber Fax: ___ - ___ - ____

Prescriber NPI #

Prescriber DEA # __ - ______

Drug Requested:

Strength _______________ Quantity _______________ Frequency 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.

Signature of Prescriber____ Date ___ / ___ / ______

By signature, the Prescriber confirms the criteria information above is accurate and verifiable in patient records

FAX TO: **COLORADO Medicaid Prior Authorizations**

Fax: (888)-772-9696

PA HELPDESK: (800) 365 - 4944