

**Department for Medicaid Services  
Tobacco Cessation Referral Form**

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**Provider Information**

Provider National Provider Identifier (NPI): \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Fax #: \_\_\_\_\_ Provider Phone #: \_\_\_\_\_

Provider Email Address (if available): \_\_\_\_\_

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**Recipient Information**

Recipient Medicaid ID: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Name: \_\_\_\_\_

Gender:  Male  Female

Pregnant?  Yes  No

Street Address: \_\_\_\_\_

Apt/Bldg#: \_\_\_\_\_

*Prescriber: Please refer to FDA guidelines regarding the use of varenicline in pregnant women.*

City: \_\_\_\_\_ County: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Primary Telephone#: \_\_\_\_\_ Secondary Telephone#: \_\_\_\_\_

Date of Visit: \_\_\_\_\_

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**Tobacco Cessation Medication Choice(s) prescribed for the recipient [to be completed by the provider]**

Nicotine replacement therapy (NRT) gum \_\_\_\_\_  NRT patch \_\_\_\_\_

NRT lozenge \_\_\_\_\_  NRT inhaler \_\_\_\_\_

NRT spray \_\_\_\_\_  Bupropion  Varenicline

**Prescription amount must be for a one-month supply with two subsequent one-month refills**

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**Support program recommended for the recipient (to be completed by the provider)**

The Cooper/Clayton Method  Freedom from Smoking® Online  Kentucky's Tobacco Quitline

GetQUIT Plan  <http://www.becomeanex.org>  <http://mylastdip.com>

<https://positivelysmokefree.org/cgi-bin/WebObjects/PSF2>  Other Program: \_\_\_\_\_

Recipient does not require support program

Support program attendance would create hardship for recipient (provider: please explain): \_\_\_\_\_

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## Recipient Commitment (to be completed by the recipient)

What kind of tobacco do you use?  Cigarette  Smokeless Tobacco  Cigar  Pipe

I am ready to quit using tobacco

I understand that my chances of quitting are better if I participate in a support program.

I understand that to get medication to help me stop using tobacco, I have to participate in the tobacco cessation support program chosen for me by my provider. If my provider has written me a prescription for medication to help me stop using tobacco, I can get the first month's supply by signing this form. Before I can get my medication refilled, I must tell Medicaid that I will continue to go to the support program chosen by my provider. To do this, I can:

- Call Medicaid at 502-564-9444, or
- Write to Tobacco Cessation Program, Kentucky Medicaid, 275 East Main Street, 6C-C, Frankfort, KY 40601 or
- Send a fax to 502-564-0223

I understand that my provider has to send a copy of this form to Kentucky Medicaid in order for me to be able to get any refills of my medication. If my provider does not do so then I must send a copy of this form to Kentucky Medicaid. Kentucky Medicaid will not pay for any refills of my medication unless they have a copy of this form.

I understand that I must, if asked, give Medicaid an update on my progress in quitting tobacco.

Recipient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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### Provider FAX Instructions

The completed and signed form must be faxed to (502) 564-0223 and a copy of the completed and signed form must be given to the recipient

**PROVIDER'S NOTE: A copy of this form must be on file with Kentucky Medicaid before your claim for the tobacco cessation assessment will be paid and in order for the recipient to receive a refill of tobacco cessation medication. If no form is on file with Kentucky Medicaid, Kentucky Medicaid will not reimburse you for the assessment and will not approve a refill of tobacco cessation medication for the recipient.**

*If you have any questions, please contact the Department for Medicaid Services, Division of Medical Management at (502) 564-9444 and mention "tobacco cessation referral" as the subject of your call*