



Date of Request: _____

Sterling Retiree Rx Prior Authorization Form

CHANTIX (Varenicline)

Indications for Coverage

Aid to smoking cessation treatment

Exclusion Criteria

Concurrent use of Zyban (bupropion HCl)

Coverage Duration: 12 weeks initial; 12 weeks additional upon renewal

Member Information

Name					
Enrollment/Card-holder ID Number					
Group/Plan		Male		Female	
Date of Birth		Age		Weight in Kg	
Street Address					
City		State		Zip	

Physicians Information

Name					
Agent		Contact Name			
Specialty/Office					
Clinic Name					
Street Address					
City		State		Zip	
Phone		Fax			

Requested Drug

CHANTIX	Reason for Request	
Condition/Diagnosis Related		

Clinical Drug/Lab History Pertinent to Request

Labs: Baseline/Ongoing	Strength/Dosage
Please List Alternative Formulary Drugs	

Comments	
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Physicians Signature: _____ Fax Form to 1-866-481-3704