

**“TOBACCO – FREE”
RX PROGRAM FORM**

Patient's Name: _____ Patient's Date of Birth: Month Day Year <table border="1" style="width:100%; height: 20px; border-collapse: collapse;"> <tr> <td style="width:33%;"></td> <td style="width:33%;"></td> <td style="width:33%;"></td> </tr> </table> Patient's Telephone Number: _____ Relationship to Employee: <table style="width:100%; text-align: center;"> <tr> <td><i>Self</i></td> <td><i>Spouse</i></td> <td><i>Child</i></td> <td><i>Other</i></td> </tr> <tr> <td style="width:25%;"><input type="checkbox"/></td> <td style="width:25%;"><input type="checkbox"/></td> <td style="width:25%;"><input type="checkbox"/></td> <td style="width:25%;"><input type="checkbox"/></td> </tr> </table>				<i>Self</i>	<i>Spouse</i>	<i>Child</i>	<i>Other</i>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Employee Name: _____ Employee ID #: (Clock Number/Alt ID) _____
<i>Self</i>	<i>Spouse</i>	<i>Child</i>	<i>Other</i>									
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>									

Smoking Cessation Class Information:

Class Location: _____

Signature of Class Leader _____

Class Telephone Phone Number: _____ - _____ - _____

Class Start Date: ____ / ____ / ____

Smoking Cessation Pharmacy Benefit

- Prior authorization is required for smoking cessation products to be covered through the pharmacy benefit plan.
- This completed form serves as a certificate of enrollment in a smoking cessation class that will be used to process drug prior authorizations.
- The completed form should be faxed to OhioHealth Group Customer Service at 614-566-0403 prior to obtaining any smoking cessation products. Once this form is received it will be processed within one (1) business day. You may then go to the pharmacy to obtain over the counter or prescription medication for smoking / nicotine cessation for up to one (1) year.
- Products/items purchased prior to authorization will not be eligible for reimbursement.
- You must be 18 years of age to receive smoking cessation medication.
- For additional information call 614-566-0155 or 1-888-838-6337.

Patient Signature: _____ **Date:** _____

FAX COMPLETED FORM TO (614) 566-0403