Kentucky Employees Health Plan
Cooper Clayton Smoking Cessation Voucher
Over-the-counter Nicotine Replacement Therapy (NRT)

Participant's Name	Daytime Phone Number
Participant's Address	City, State, Zip
Insurance Planholder's Name	Last 4 Digits of Planholder's SSN
Facilitator Name (Print) Phone Number	Cooper Clayton Program Location

Week 1 **Facilitator Signature**	**Date**	Week 3 **Facilitator Signature**	**Date**
DEI Approval	Date	Approval Valid Until	
Week 1 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____	Week 2 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____	Week 3 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____	Week 4 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____

Week 5 **Facilitator Signature**	Date	Week 7 **Facilitator Signature**	Date
DEI Approval	Date	Approval Valid Until	
Week 5 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____	Week 6 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____	Week 7 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____	Week 8 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____

Week 9 **Facilitator Signature**	Date	Week 11 **Facilitator Signature**	Date
DEI Approval	Date	Approval Valid Until	
Week 9 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____	Week 10 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____	Week 11 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____	Week 12 Recommended Dosage ☐ **Patch Dosage:** ☐21 mg ☐14 mg ☐ 7 mg Pkg. Qty for 2 week period_____ ☐ **Lozenge Dosage:** ☐4 mg ☐2 mg Pkg. Qty for 2 week period_____ ☐ **Gum Dosage:** ☐ 4 mg ☐ 2 mg Pkg. Qty for 2 week period_____

****BENEFIT LIMITATION****
Each participant is eligible to receive a 3-month supply of OTC NRT each calendar year.

Please contact the Department for Employee Insurance with any questions
Personnel Cabinet
Department for Employee Insurance
200 Fair Oaks Lane, Suite 501
Frankfort, KY 40601
(888) 581-8834 or (502) 564-6534
(502) 564-0364 (Fax)

Pharmacist:
Vouchers signed by DEI staff indicate that a Prior Authorization has been issued for a one month supply of the product indicated above and is valid until the date indicated. Claims should be filed through Express Scripts. If the member is purchasing two different strengths of the product indicated above, the claims must be filed separately. However, the member can only receive the total of what is indicated. Please use your store DEA number in the Prescriber ID field (411-DB) since a script is not required to fill this claim.