

Kentucky Employee's Health Plan (KEHP)  
Cooper Clayton Smoking Cessation Program  
Voucher for Over-the-Counter Nicotine Replacement Therapy



Participant's Name (First, Last, MI)	Daytime Phone Number	Fax Number
Participant's Address	City, State, Zip	Participant's Date of Birth
Insurance Planholder's Name	Last 4 Digits of Planholder's SSN	
Facilitator's Name (Print)	Facilitator's Phone Number	Program Location (city/county)

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Facilitator Signature	Date:	Facilitator Signature	Date:
<b>Weeks 1 &amp; 2 Recommended Dosage</b>		<b>Weeks 3 &amp; 4 Recommended Dosage</b>	
<input type="checkbox"/> Patch Dosage: <input type="checkbox"/> 21 mg <input type="checkbox"/> 14 mg <input type="checkbox"/> 7 mg Qty needed for 2-week period _____	<input type="checkbox"/> Lozenge Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____	<input type="checkbox"/> Patch Dosage: <input type="checkbox"/> 21 mg <input type="checkbox"/> 14 mg <input type="checkbox"/> 7 mg Qty needed for 2-week period _____	<input type="checkbox"/> Lozenge Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____
<input type="checkbox"/> Gum Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____	<b>Select only one product and one dosage for a 2-week period</b>	<input type="checkbox"/> Gum Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____	<b>Select only one product and one dosage for a 2-week period</b>

Facilitator Signature	Date:	Facilitator Signature	Date:
<b>Weeks 5 &amp; 6 Recommended Dosage</b>		<b>Weeks 7 &amp; 8 Recommended Dosage</b>	
<input type="checkbox"/> Patch Dosage: <input type="checkbox"/> 21 mg <input type="checkbox"/> 14 mg <input type="checkbox"/> 7 mg Qty needed for 2-week period _____	<input type="checkbox"/> Lozenge Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____	<input type="checkbox"/> Patch Dosage: <input type="checkbox"/> 21 mg <input type="checkbox"/> 14 mg <input type="checkbox"/> 7 mg Qty needed for 2-week period _____	<input type="checkbox"/> Lozenge Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____
<input type="checkbox"/> Gum Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____	<b>Select only one product and one dosage for a 2-week period</b>	<input type="checkbox"/> Gum Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____	<b>Select only one product and one dosage for a 2-week period</b>

Facilitator Signature	Date:	Facilitator Signature	Date:
<b>Weeks 9 &amp; 10 Recommended Dosage</b>		<b>Weeks 11 &amp; 12 Recommended Dosage</b>	
<input type="checkbox"/> Patch Dosage: <input type="checkbox"/> 21 mg <input type="checkbox"/> 14 mg <input type="checkbox"/> 7 mg Qty needed for 2-week period _____	<input type="checkbox"/> Lozenge Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____	<input type="checkbox"/> Patch Dosage: <input type="checkbox"/> 21 mg <input type="checkbox"/> 14 mg <input type="checkbox"/> 7 mg Qty needed for 2-week period _____	<input type="checkbox"/> Lozenge Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____
<input type="checkbox"/> Gum Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____	<b>Select only one product and one dosage for a 2-week period</b>	<input type="checkbox"/> Gum Dosage: <input type="checkbox"/> 4 mg <input type="checkbox"/> 2 mg Qty needed for 2-week period _____	<b>Select only one product and one dosage for a 2-week period</b>

**\*IMPORTANT NOTE\***

Using this form, over-the-counter nicotine replacement therapy (OTC NRT) may be obtained without a prescription and without any cost to the Member/Participant. After Week 12 of the program, a prescription will be required to obtain OTC NRT without any cost to the Member.

Please contact the Department of Employee Insurance with any questions.

Personnel Cabinet  
Department of Employee Insurance  
501 High Street, 2<sup>nd</sup> Floor  
Frankfort, KY 40601  
(888) 581-8834 or (502) 564-6534  
(502) 564-1085 (Fax)

**KEHP Use Only**

Approval Date \_\_\_\_\_

KEHP Authorized Signature \_\_\_\_\_

Approval Valid Until \_\_\_\_\_

**Pharmacist:** This Voucher, when approved by KEHP, entitles the Participant named above to a 28-day supply of the product indicated. This product is provided without any cost to the Participant. Claims should be filed through CVS/Caremark. If the KEHP approval is for two different strengths of an NRT, a separate claim must be filed for each. The Participant can only receive the total quantity of the product that is authorized by the program facilitator/counselor and approved by KEHP. Please use your store DEA number in the Prescriber ID field (411-DB) since a prescription is not required to process this claim.