

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

Participant's Name	Daytime Phone Number	Fax 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		Approval Valid Until	
<b>Week 1 &amp; 2 Recommended Dosage</b>		<b>Week 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 two 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 two week period.</b>

Week 5 Facilitator Signature	Date	Week 7 Facilitator Signature	Date
DEI Approval		Approval Valid Until	
<b>Week 5 &amp; 6 Recommended Dosage</b>		<b>Week 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 two 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 two week period.</b>

Week 9 Facilitator Signature	Date	Week 11 Facilitator Signature	Date
DEI Approval		Approval Valid Until	
<b>Week 9 &amp; 10 Recommended Dosage</b>		<b>Week 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 two 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 two week period.</b>

**\*\*BENEFIT LIMITATION\*\***

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

Please contact the Department of Employee Insurance with any questions  
 Personnel Cabinet  
 Department of Employee Insurance  
 501 High Street, Second Floor  
 Frankfort, KY 40601  
 (888) 581-8834 or (502) 564-6534  
 (502) 564-1085 (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.