

New TeamstersCare Smoking Cessation Medication Coverage
Effective May 1, 2007

The TeamstersCare Board of Trustees has approved coverage for Chantix®, a prescription medication used to treat smoking addiction, for members and their eligible dependents who want to quit smoking.

Coverage for **Chantix®** works as follows:

- *The patient fills the initial prescription for 12 weeks of Chantix® at a retail pharmacy and enrolls in any smoking cessation program. GetQuit, TrytoStop, and programs sponsored by the American Cancer Society, are some examples.*
- *He/She submits prescription receipts, and a certificate of completion of a smoking cessation program to TeamstersCare Member Services for reimbursement. TeamstersCare will reimburse the total cost of the prescription minus a \$25.00 co-pay per prescription.*
- *If needed, the patient may fill a prescription for an additional 12 weeks of Chantix® only at a TeamstersCare pharmacy with a \$15 co-pay.*
- *The maximum reimbursement for Chantix® will be for a total of up to 24 weeks in a 12 month period.*

To obtain reimbursement:

1. Complete *all* sections on the reverse side of this form. Be sure to *sign* and *date* as indicated.
2. Attach legible *copies of your prescription receipts* (**cancelled checks, cash register receipts or charge card receipts are not valid**). Keep your *original receipts* and proofs of payment for your records.
3. The prescription receipts must include:
 - Name of person receiving the prescription,
 - Name of medication,
 - Name of prescribing physician,
 - Date of purchase,
 - Prescription number; and
 - Total charge for the prescription (amount for which you are requesting reimbursement)
4. Send the **completed form** with a **copy of proof of completion of a Smoking Cessation Program** to TeamstersCare Member Services at 16 Sever Street, Charlestown, MA 02129-1309. You may want to keep a copy of the form for your records.

Click here for a link to the Chantix Smoking Cessation Program Reimbursement Claim Form

TeamstersCare **Chantix®** Reimbursement Claim Form

Member Name: _____ Social Security Number: _____

Address: _____

Name of member or eligible dependent receiving medication: _____

Patient Date of Birth: _____

PRESCRIPTIONS FOR WHICH YOU REQUEST REIMBURSEMENT

Prescription Name	Provider of Prescriptions	Date of Purchase	Amount Paid
Chantix®			
Chantix®			
Chantix®			

CERTIFICATE OF COMPLETION FROM A SMOKING CESSATION PROGRAM

NAME OF PROGRAM: _____

DATE OF COMPLETION: _____

- *Please provide TeamstersCare with a copy of the certificate of completion.*
- *Note: TeamstersCare does not reimburse for a “Smoking Cessation Program,” but you can submit the expense through the Health Bonus Account.*

Member’s Signature

Date

TeamstersCare Office Use Only

Program Start Date: _____ Program End Date: _____

Eligible for TeamstersCare Pharmacy Prescriptions: _____