

## DIABETIC BLOOD GLUCOSE METERS & TEST STRIPS PRIOR AUTHORIZATION FORM

- Please complete all applicable sections of this prior authorization request form and return to the fax number above. Please **include all requested documentation** (chart notes, laboratory data, etc.).
- To review the prior authorization guidelines for Diabetic Meters and Strips, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapters – **Diabetic Meters** and **Diabetic Strips** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to Quantity Limits list at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).

PRIOR AUTHORIZATION REQUEST INFORMATION			PRESCRIBER INFORMATION	
<input type="checkbox"/> New request	<input type="checkbox"/> Additional info	# of pages in request: _____	Prescriber name:	
<input type="checkbox"/> Renewal request	PA#: _____			
Name of office contact:			Specialty:	
Contact's phone number:			State license #:	
Facility contact/phone:			NPI:	MA Provider ID#:
RECIPIENT INFORMATION			Street address:	
Recipient Name:			Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:	

### CLINICAL INFORMATION

<b>Non-preferred product requested:</b>	<input type="checkbox"/> blood glucose meter ( <i>name</i> ):																						
	<input type="checkbox"/> blood glucose test strips ( <i>name</i> ):																						
Directions:	Quantity:	Refills:																					
1. Has the Recipient tried all of the preferred products from both of the preferred manufacturers? <i>Check all that apply and submit supporting documentation.</i>																							
<table style="width: 100%; border: none;"> <tr> <td style="width: 25%;"><b><u>Abbott meters</u></b></td> <td style="width: 25%;"><b><u>Abbott strips</u></b></td> <td style="width: 25%;"><b><u>Lifescan meters</u></b></td> <td style="width: 25%;"><b><u>Lifescan strips</u></b></td> </tr> <tr> <td><input type="checkbox"/> Freestyle Insulinx</td> <td><input type="checkbox"/> Freestyle</td> <td><input type="checkbox"/> One Touch Ultra</td> <td><input type="checkbox"/> One Touch Ultra</td> </tr> <tr> <td><input type="checkbox"/> Freestyle Lite</td> <td><input type="checkbox"/> Freestyle Insulinx</td> <td><input type="checkbox"/> One Touch Ultra 2</td> <td><input type="checkbox"/> One Touch Verio</td> </tr> <tr> <td><input type="checkbox"/> Freestyle Freedom Lite</td> <td><input type="checkbox"/> Freestyle Lite</td> <td><input type="checkbox"/> One Touch Ultra Mini</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Precision Xtra</td> <td><input type="checkbox"/> Precision Xtra</td> <td><input type="checkbox"/> One Touch Verio IQ</td> <td></td> </tr> </table>				<b><u>Abbott meters</u></b>	<b><u>Abbott strips</u></b>	<b><u>Lifescan meters</u></b>	<b><u>Lifescan strips</u></b>	<input type="checkbox"/> Freestyle Insulinx	<input type="checkbox"/> Freestyle	<input type="checkbox"/> One Touch Ultra	<input type="checkbox"/> One Touch Ultra	<input type="checkbox"/> Freestyle Lite	<input type="checkbox"/> Freestyle Insulinx	<input type="checkbox"/> One Touch Ultra 2	<input type="checkbox"/> One Touch Verio	<input type="checkbox"/> Freestyle Freedom Lite	<input type="checkbox"/> Freestyle Lite	<input type="checkbox"/> One Touch Ultra Mini		<input type="checkbox"/> Precision Xtra	<input type="checkbox"/> Precision Xtra	<input type="checkbox"/> One Touch Verio IQ	
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2. Why can't the Recipient use any of the preferred blood glucose meters and/or strips? ( <i>Document reason(s) in the space provided and submit supporting documentation.</i> )																							
3. <b>If the request exceeds the quantity limits of 1 meter per 365 days and/or 5 strips per day</b> , document reason(s) for exceeding the quantity limits in the space provided and <i>submit supporting documentation.</i>																							

**PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature:	Date:
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