PRESCRIPTION DRUG
MEDICATION REQUEST FORM
FAX TO 1-866-240-8123

DIABETIC TESTING SUPPLIES PRIOR AUTHORIZATION FORM

PATIENT INFORMATION

Subscriber's ID Number			Subscriber's Group Number
Patient's Name		Phone	Date of Birth
Address	City	State	Zip Code

PRESCRIBER INFORMATION

Physician's Name	NPI	Phone	Fax
Address	City	State	Zip Code
Suite / Building	Physician's Signature		Date

MEDICATION INFORMATION

Requested Product:	
Diagnosis:	
Quantity:	Day Supply:

CLINICAL CRITERIA

1. Does the patient have a diagnosis of diabetes mellitus?
   ☐ Yes ☐ No

2. Has the treating practitioner concluded that the patient (or the patient's caregiver) has had sufficient training using the requested product, as evidenced by providing a prescription for the appropriate supplies and frequency of blood glucose testing?
   ☐ Yes ☐ No

3. Is the requested product being used for testing daily blood glucose levels?
   ☐ Yes ☐ No

4. Is the patient insulin-treated?
   ☐ Yes ☐ No

5. Does the patient have a history of problematic hypoglycemia with documentation of recurrent (more than one) level 2 hypoglycemic events [glucose less than 54mg/dL (3.0mmol/L)] that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan?
   ☐ Yes ☐ No

6. Does the patient have a history of problematic hypoglycemia with documentation of a history of one level 3 hypoglycemic event [glucose less than 54mg/dL (3.0mmol/L)] characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia?
   ☐ Yes ☐ No

7. Has the treating practitioner had an in-person visit or Medicare-approved telehealth visit with the patient within the last six (6) months to evaluate their diabetes control and determined that the criteria above are met?
   ☐ Yes ☐ No

8. Will the treating practitioner have an in-person visit or Medicare-approved telehealth visit with the patient every six (6) months following the initial prescription of the requested product to assess adherence to their regimen and diabetes treatment plan?
   ☐ Yes ☐ No

9. Is the quantity of diabetic testing supplies being requested necessary for the patient?
   ☐ Yes ☐ No

10. Does the patient use an insulin pump?
    ☐ Yes ☐ No

11. Does the patient have a severe visual impairment (i.e. best corrected visual acuity of 20/200 or worse in both eyes) requiring use of a special monitoring system?
    ☐ Yes ☐ No

12. Does the patient have an impairment of manual dexterity severe enough to require the use of a special monitoring system?
    ☐ Yes ☐ No

13. Please list all previously tried products:

    _____

    _____

    _____

    _____

The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **Clinical Services,**
   120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222