HIGHMARK | HIGHMARK

Prior Authorization Form
Fax to 1-866-240-8123

DIABETIC TESTING SUPPLIES

Member Information:

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

Provider Information:

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

Requested Product Information:

Product Name	Requested Quantity	Requested Day Supply
		☐ 30 days ☐ 90 days ☐ Other: _____
Directions		
Diagnosis and/or ICD-10 code(s)		

Clinical Information:

1. Does the member have a diagnosis of diabetes mellitus?	Yes	No
2. Is the member pregnant?	Yes	No
2a. If the member is pregnant, does the member have a diagnosis of gestational diabetes?	Yes	No
3. Does the member have a history of poorly controlled diabetes (for example, unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia, recurrent diabetic ketoacidosis)? ***If yes, please include chart notes to support this information.**	Yes	No
4. Has the treating practitioner concluded that the member (or the member'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

5. Is the requested product being used for testing daily blood glucose levels?	Yes	No
6. Is the member insulin-treated? ***If yes, please include chart notes to support this information.**	Yes	No
6a. If the member is insulin-treated, is the member using an insulin pump? ***If yes, please include chart notes to support this information.**	Yes	No
7. Does the member have a history of problematic hypoglycemia with documentation of:		
7a. 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
7b. 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
8. Has the member experienced problematic hypoglycemia (specifically, nocturnal hypoglycemia, hypoglycemic unawareness, frequent/severe hypoglycemia defined as blood glucose less than 50 mg/dL)? ***If yes, please include chart notes to support this information.**	Yes	No
9. Has the treating practitioner had an in-person visit or Medicare-approved telehealth visit with the member within the last six (6) months to evaluate their diabetes control?	Yes	No
10. Will the treating practitioner have an in-person visit or Medicare-approved telehealth visit with the member every six (6) months following the initial prescription of the requested product to assess adherence to their regimen and diabetes treatment plan?	Yes	No
11. Is the quantity of diabetic testing supplies being requested necessary for the member?	Yes	No
12. Does the member 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
13. Does the member have an impairment of manual dexterity severe enough to require the use of a special monitoring system?	Yes	No

Product History:

Please provide any other products that the member has tried and failed:

_____

_____

_____

***Please include chart notes to support any previous product failures, intolerance, or contraindications.**

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 member. 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. Please print, type or write legibly in blue or black ink.
3. Complete **ALL** information on the form.
   NOTE: *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
4. Please provide the physician address as it is required for physician notification.
5. Fax the **completed** form and all clinical documentation to **1-866-240-8123**
   Or mail the form to: **120 Fifth Avenue, SPECARE, Pittsburgh, PA 15222**