



Diabetic Testing Supplies Prior Authorization Request Form

Ph: (866) 503-0857
Fax: (877) 269-9916

MEMBER INFORMATION		PRESCRIBER INFORMATION	
Member name		Today's date	Physician specialty
Member ID		Physician name	NPI/DEA number
Member Address, City, State, ZIP		Physician Address, City, State, ZIP	
Member phone number		M.D. office phone number	
Gender <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth	M.D. office fax number	

MEDICATION INFORMATION

The following is a list of preferred blood glucose meters and test strips:
Please consider switching to one of the preferred products.

- OneTouch® Ultra® 2 System with OneTouch® Ultra® test strips
- OneTouch® UltraMini® with OneTouch® Ultra test strips
- OneTouch® Verio® with OneTouch® Verio® test strips
- OneTouch® Verio® IQ with OneTouch® Verio® test strips
- OneTouch® Verio® Flex™ System Kit with OneTouch® Verio® test strips

REQUEST IS FOR

Meter (Please provide brand name) _____

Test Strips (Please provide brand name) _____

DIAGNOSIS INFORMATION

Primary ICD code _____ Secondary ICD code _____ Other _____

CLINICAL INFORMATION

Yes No The member is able to use a preferred LifeScan product and will be switched to a preferred LifeScan product. Please provide the member with a new prescription for the preferred product.

If the member cannot be switched to a preferred LifeScan product, select the clinical reason(s):

Member is Blind & Requires a Talking Meter

Member uses insulin pump which is synced with current Non-LifeScan Meter
Name of the insulin pump the member is using _____

Member is mentally impaired making re-training on new LifeScan Meter inadvisable.

Member is Visually Impaired despite correction (i.e. glasses)
 Yes No Has the member tried One Touch Verio Flex?
Provide the medical reason the member can't use this LifeScan option _____

Member has limited dexterity or unstable hand movements (i.e. arthritis, MS, Parkinson's)
 Yes No Has the member tried One Touch Verio Flex?
Provide the medical reason the member can't use this LifeScan option _____

Member requires simple monitor
 Yes No Has the member tried One Touch Verio Flex?
Provide the medical reason the member can't use this LifeScan option _____

Member needs low volume meter < than 0.4 ul blood volume
 Yes No Has the member tried one of the One Touch Verio products (Verio, Verio Flex, or Verio IQ)?
Provide the medical reason the member can't use a LifeScan option _____

Other, Explain: _____

QUANTITY LIMIT REQUESTS (No prior authorization required for up to three test strips per day)

How many times per day is the member testing? _____

Quantity requested _____ Days supply requested _____

Date of last in-person office visit to evaluate the member's diabetes control _____

Yes No Is there documentation in the medical record supporting the specific testing frequency?

Yes No The member has a medical condition that requires more frequent testing

Please describe: _____

ACKNOWLEDGEMENT

Request Completed By (Signature Required): _____ **Date:** ____ / ____ / ____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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