Prior Authorization Form

DIABETIC TEST STRIPS

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)*

- ☐ **LifeScan One Touch® (*specify brand)*** ______________________________
- ☐ **Accu-Check® (*specify brand)*** ______________________________
- ☐ **Other** ______________________________

Date: ______________________ Patient ID#: ______________ DOB: __________

Patient Name: ______________________ Provider NPI: ______________________

Prescribing Physician: ______________________ Office Contact: ______________________

Office Fax #: ______________________ Office Phone: ______________________

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

A. Has the patient had a 30 day trial and failure to ONE test strip from <u>EACH</u> of the following preferred manufacturers? (<u>MUST</u> *check all that apply below*) ☐ **YES** ☐ **NO**

I) BAYER:

☐ Ascensia Auto disc ☐ Ascensia Breeze 2 ☐ Ascensia Contour ☐ Ascensia ELITE

II) ABBOTT:

☐ Freestyle Lite ☐ FreeStyle ☐ Precision XTRA

B. Does the patient have significant visual impairment that requires the use of an audio playback of testing results? ☐ **YES** ☐ **NO**

C. Does the patient currently use an insulin pump that employs radio frequency technology? ☐ **YES** ☐ **NO**

Please list any other strips that the patient has tried:

Drug Name	**Date**	**Duration**

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

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FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only **Coverage effective date** / /

Document #______________________ Processor Initials__________ Date__________________

M F Rx coverage Y N STANDARD - SELECT LOB__________________

Previous Auth Y N **Approved** **Reviewer Initials**____________ Date____________