FUTURE SCRIPTS

Please complete ALL information below and fax your request to 1-888-671-5285

Diabetic Test Strips Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if **generic substitution** is acceptable ❑ Check if request is for **continuation of therapy**	Directions for Use:	

Clinical Information (required)

Select the products the patient has had a trial of:

❑ Accu-Chek test strips (e.g., Accu-Chek Aviva, Accu-Chek Compact)

❑ OneTouch test strips (e.g., OneTouch Basic, OneTouch Sure Step)

Clinical information:

Is the requested test strip required because it is the only product that will interface with the patient's insulin pump? ❑ **Yes** ❑ **No**

Quantity limit requests:

What is the quantity requested per MONTH? _____

Does the physician confirm that the patient requires a greater quantity because of more frequent blood glucose testing (e.g., patients on intravenous insulin infusions)? ❑ **Yes** ❑ **No**

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.