



# Prior Authorization Request Form for Blood Glucose Meter & Test Strips

FAX this completed form to (844) 205-3386

OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720

OR Prior authorization may be completed at <https://www.covermymeds.com/main/prior-authorization-forms/>

I. PROVIDER INFORMATION		II. MEMBER INFORMATION	
Prescriber Name:		Member Name:	
Prescriber Specialty:		Identification #:	
NPI:		Group #:	
Office Contact Name:		Date of Birth:	
Fax #:		Medication Allergies:	
Phone #:			
III. DRUG INFORMATION (One drug request per form)			
Meter or Test Strips name:		Quantity:	
Testing frequency:	Refills:		
IV. REQUIRED DOCUMENTATION (Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)			
Specify diagnosis & diagnosis code relevant to this request:		Dx/Dx Code: _____	
Is the member pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the member use insulin?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the member use an insulin pump?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>Requests for all non-preferred meter/test strips:</b> Did the member try the preferred Blood Glucose Meter and Test Strips? <i>Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred medications in this class. Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.</i>			
<input type="checkbox"/> Ascencia/Contour: _____			
<input type="checkbox"/> Lifescan/One Touch: _____			
<input type="checkbox"/> <b>For requests exceeding 1 meter per 365 days and/or 3 strips per day</b> , document reason(s) for exceeding the quantity limits and submit supporting documentation, including testing logs:			
<b>SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.</b>			
<b>RENEWAL REQUESTS:</b>			
<input type="checkbox"/> Rationale for continued use of requested medication: _____			
IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :			

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.

Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)