

## Clinical Policy: Blood Glucose Meters (glucometers) and Test Strips

Reference Number: PHW.PDL.107

Effective Date: 01/01/2020

Last Review Date: 11/2023

[Revision Log](#)

### Policy/Criteria

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of PA Health and Wellness® that Blood Glucose Meters (glucometers) and Test Strips are **medically necessary** when the following criteria are met:

### I. Requirements for Prior Authorization of Blood Glucose Meters and Test Strips

#### A. Prescriptions That Require Prior Authorization

Prescriptions for Blood Glucose Meters (glucometers) and Test Strips that meet any of the following conditions must be prior authorized:

1. A non-preferred Blood Glucose Meter (glucometer).
2. A non-preferred Blood Glucose Test Strip.
3. A Blood Glucose Meter or Test Strip with a prescribed quantity that exceeds the quantity limit.

#### B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Blood Glucose Meter or Test Strip, the determination of whether the requested product is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Blood Glucose Meter, has a documented history of trial and failure of the use of the preferred Blood Glucose Meters; **AND**
2. For a non-preferred Blood Glucose Test Strip, has a documented history of trial and failure of the use of the preferred Blood Glucose Meters; **AND**
3. If a prescription for a Blood Glucose Meter or Test Strip is in a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Override.

NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary

to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Blood Glucose Meter or Test Strip. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Approval Duration: 12 months

Reviews, Revisions, and Approvals	Date
Policy created	01/01/2020
Q3 2020 annual review: no changes.	07/2020
Q1 2021 annual review: no changes.	01/2021
Q1 2022 annual review: no changes.	11/2021
Q1 2023 annual review: no changes.	11/2022
Q1 2024 annual review: no changes.	11/2023