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 DOCUMENTION *(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? ☐ Yes-submit documentation ☐ No

Does the member use insulin? ☐ Yes-submit documentation ☐ No

Does the member use an insulin pump? ☐ Yes-submit documentation ☐ No

Requests for all non-preferred meter/test strips: Did the member try the preferred Blood Glucose Meter and Test Strips?
Refer to https://papdl.com/preferred-drug-list 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.

☐ Ascencia/Contour:_____

☐ Lifescan/One Touch:_____

☐ **For requests exceeding 1 meter per 365 days and/or 3 strips per day**, document reason(s) for exceeding the quantity limits and submit supporting documentation, including testing logs:

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

RENEWAL REQUESTS:

☐ 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.)