BLOOD GLUCOSE METERS & TEST STRIPS PRIOR AUTHORIZATION FORM

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/

Prior authorization guidelines for **Blood Glucose Meters and Test Strips** and **Quantity Limits/Daily Dose Limits** are available on the PA Health & Wellness website at https://www.pahealthwellness.com/providers/pharmacy.html

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
Facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested:	☐Blood glucose meter (*name*):		
	☐Blood glucose test strips (*name*):		
Testing frequency:		Quantity:	Refills:
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

For NON-PREFERRED meters/test strips: Did the member try the preferred meters/test strips from both preferred manufacturers? *Indicate meters tried and submit supporting documentation. Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Blood Glucose Meters and Test Strips.*

☐Accu-Chek Guide/Guide Me (Roche): _____

☐TrueMetrix (Trividia): _____

For NON-PREFERRED meters/test strips: Why can't the member use the preferred meters/test strips? *Document reason(s) in the space provided and submit supporting documentation.*

For requests that EXCEED THE QUANTITY LIMITS of 1 meter per 365 days and/or 5 strips per day, *Document reason(s) for exceeding the quantity limits in the space provided and submit supporting documentation, including testing logs.*

pa health & wellness™

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO 844-205-3386

Prescriber 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.)