GLUCOSE TEST STRIPS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit www.myprime.com

PATIENT AND INSURANCE INFORMATION **Today's date:** _____

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State:	ZIP:	Patient Phone:
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

MEDICAL INFORMATION. PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED.

Patient Diagnosis with ICD-9 Code:	ICD-10 Code:	
Medication and Strength Requested:		
Dosing Schedule:		Quantity per Month:

NOTE: The preferred strips/disks and meters are Bayer products.

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

_____ Date range: _____ _____ Date range:_____
_____ Date range: _____ _____ Date range:_____
_____ Date range: _____ _____ Date range:_____

Is the patient currently treated with the requested agent? ☐ Yes ☐ No

Does the patient require glucose testing more than six times daily (204 units/month)? ☐ Yes ☐ No

If yes: Is the patient prescribed insulin? ☐ Yes ☐ No

If yes: Does the patient meet either of the following? (Check all that apply.) ☐ Yes ☐ No

☐ Patient administers multiple injections per day that would require testing more than 6 times per day

☐ Patient is using an insulin pump and requires testing more than 6 times per day based on blood monitoring frequency

Please provide any additional explanation to support daily testing exceeding six times daily: _____

_____

_____

_____

Please continue to the next page.

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):

Does the patient have severe visual impairment with an inability to use a standard meter? ☐ Yes ☐ No

Is the patient legally blind? ☐ Yes ☐ No

If yes: Is the patient's vision in the better eye 20/200 or worse after best correction with glasses or contact lenses? ☐ Yes ☐ No

Does the patient use an insulin pump or continuous glucose monitor that is incompatible with the preferred test strip products: Ascensia products (e.g., Contour test strips) and LifeScan products (e.g., OneTouch test strips)? ☐ Yes ☐ No

Please indicate:

☐ Date of service (if applicable): (mm/dd/yyyy): _____

☐ Start of treatment: Start date (mm/dd/yyyy): _____

☐ Continuation of therapy: Date of last treatment (mm/dd/yyyy): _____

What is the priority level of this request?

☐ Standard

☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

If yes: Please specify: _____

_____

Please fax or mail this form to:
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Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183