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.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
   If yes, is the patient stable on the requested agent? ☐ Yes ☐ No
2. Has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? ☐ Yes ☐ No
3. Has the patient tried and had an inadequate response to a preferred glucose test strip (Ascensia and Lifescan products)? ☐ Yes ☐ No
4. Was a preferred glucose test strip (Ascensia and Lifescan products) discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
5. Does the patient have an intolerance or hypersensitivity to a preferred glucose test strip (Ascensia and Lifescan products)? ☐ Yes ☐ No
6. Does the patient have an FDA labeled contraindication to ALL preferred glucose test strips (Ascensia and Lifescan products)? ☐ Yes ☐ No
7. Is a preferred glucose test strip (Ascensia and Lifescan products) expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the glucose test strip; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
8. Is a preferred glucose test strip (Ascensia and Lifescan products) not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
9. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action as a preferred glucose test strip (Ascensia and Lifescan products) and that glucose test strip was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No

Please continue to the next page.

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

10. Is the requested agent medically necessary and appropriate for the patient? ☐ Yes ☐ No
11. Does the patient have visual impairment? ☐ Yes ☐ No
12. Does the patient use an insulin pump OR continuous glucose monitor that is not accommodated with a preferred glucose cartridge or test strip (Ascensia and Lifescan products)? ☐ Yes ☐ No
    If yes, please explain: _____
    _____
13. Does the patient have a physical or a mental disability? ☐ Yes ☐ No
    If yes, please explain: _____
    _____
14. Is there support indicating the need for additional blood glucose testing? ☐ Yes ☐ No
    If yes, please provide supporting information: _____
    _____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
BCBSIL: 800.285.9426
BCBSMT: 888.723.7443
BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525