



PRESCRIPTION DRUG  
MEDICATION REQUEST FORM  
FAX TO 1-866-240-8123

**DIABETIC TESTING SUPPLIES PRIOR AUTHORIZATION FORM**  
**PATIENT INFORMATION**

Subscriber ID Number		Group Number	
Patient Name	Patient Telephone Number	Date of Birth	
Patient Address	City	State	Zip Code

**PRESCRIBER INFORMATION**

Physician Name		Phone	Fax
Physician Address		City	State Zip Code
Suite / Building	Physician Signature		Date

**MEDICATION INFORMATION**

Requested Product:	
Diagnosis:	
Quantity:	Day Supply:

**CLINICAL CRITERIA**

1. Has the patient (or the patient's caregiver) had sufficient training using the requested product, as evidenced by providing a prescription for the appropriate supplies and frequency of blood glucose testing?  
 Yes     No
2. Has the patient had an in-person visit with the provider within the last six (6) months to evaluate their diabetes control?  
 Yes     No
3. Has the patient had an in-person visit with the provider within the last six (6) months to evaluate their need for the specific quantity of supplies being requested?  
 Yes     No
4. Will the patient have an in-person visit with the provider every six (6) months following the initial prescription of the requested product to assess adherence to their regimen and diabetes treatment plan?  
 Yes     No
5. Is the patient insulin-treated with multiple (three or more) daily administrations of insulin or a continuous subcutaneous insulin infusion (CSII) pump?  
 Yes     No
6. Does the patient's insulin treatment regimen require frequent adjustment by the patient on the basis of BGM (blood glucose monitor) or CGM (continuous glucose monitor) testing results?  
 Yes     No
7. Does the patient use an insulin pump?  
 Yes     No
8. Does the patient have a severe visual impairment (i.e. best corrected visual acuity of 20/200 or worse in both eyes) requiring use of a special monitoring system?  
 Yes     No

9. Does the patient have an impairment of manual dexterity severe enough to require the use of a special monitoring system?

Yes       No

10. Please list all previously tried products:

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The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient. Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

## INSTRUCTIONS FOR COMPLETING THIS FORM

1. Submit a separate form for each medication.
2. Complete **ALL** information on the form.  
**NOTE:** *The prescribing physician (PCP or Specialist) should, in most cases, complete the form.*
3. Please provide the physician address as it is required for physician notification.
4. Fax the **completed** form and all clinical documentation to **1-866-240-8123**

Or mail the form to:      **Clinical Services,  
120 Fifth Avenue, MC PAPHM-043B, Pittsburgh, PA 15222**

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