HIGHMARK

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