UnitedHealthcare Community Plan

# Diabetic Meter and Test Strips - Pennsylvania
## Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.**
**Allow at least 24 hours for review.**

| Member Information | | | Prescriber Information | | |
|---|---|---|---|---|---|
| Member Name: | | | Provider Name: | | |
| Member ID: | | | NPI #: | Specialty: | |
| Date Of Birth: | | | Office Phone: | | |
| Street Address: | | | Office Fax: | | |
| City: | State: | ZIP Code: | Office Street Address: | | |
| Phone: | Allergies: | | City: | State: | ZIP Code: |

**Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____**
**Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____**
**Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____**

## Medication Information

| | |
|---|---|
| **Medication:** | **Strength:** |
| **Directions for use:** | **Quantity:** |

**Medication Administered:** ☐ Self-Administered ☐ Physician's Office ☐ Other: _____

## Clinical Information

**What is the patient's diagnosis for the medication being requested? _____**

**_____**

**ICD-10 Code(s): _____**

**Are there any supporting laboratory or test results related to the patient's diagnosis***? (Please specify or provide documentation)*

## Previous Medication Trials / Contraindications

**Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives**

**What medication(s) does the patient have a history of failure to?** *(Please specify ALL medication(s)/strengths tried, directions, length of trial, and reason for discontinuation of each medication)*

**What medication(s) does the patient have a contraindication or intolerance to?** *(Please specify ALL medication(s) with the associated contraindication to or specific issues resulting in intolerance to each medication)*

## Additional information that may be important for this review

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| Member First name: | Member Last name: | Member DOB: |
|---|---|---|

| Clinical and Drug Specific Information | |
|---|---|
| □ Yes □ No | **Does the patient have a documented history of trial and failure of the use of the preferred blood glucose meters?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)* |
| □ Yes □ No | **Does the patient have a documented history of trial and failure of the use of the preferred blood glucose test strips?** *(If yes, complete "Previous Medication Trials/Contraindications" section on first page)* |

**Provider Signature:** _____ **Date:** _____