ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Test Strips - Colorado
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.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

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: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

ROCKY MOUNTAIN HEALTH PLANS®
A UnitedHealthcare Company

Test Strips - Colorado
Prior Authorization Request Form

Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

Preferred Test Strips/Meters Include:

OneTouch:	Phone Number	Website
Ultra and Verio	1-800-285-9814	www.onetouch.orderpoints.com

Preferred meters can be obtained directly from the manufacturer (please see contact info above)

ALL REQUESTS	
□ Yes □ No	**Does the patient have a history of failure, contraindication, or intolerance to BOTH preferred test strip products: OneTouch Ultra and OneTouch Verio?** *(If yes, complete Section D above)*
□ Yes □ No	**Is the patient on an insulin pump?**
QUANTITY LIMIT REQUESTS *Please Note: Quantity Limit for insulin-dependent or pregnant patients is 6 test strips/day.* *Quantity Limit for non-insulin dependent and non-pregnant patients is 2 test strips/day.*	
□ Yes □ No	**Is the patient insulin dependent or pregnant?**
□ Yes □ No	**Does the physician confirm that the patient requires a greater quantity because of more frequent blood glucose testing (e.g. patient's on intravenous insulin infusions)?**
□ Yes □ No	**Is the patient experiencing or is prone to hypoglycemia or hyperglycemia and requires additional testing to achieve glycemic control?**
□ Yes □ No	**Is the patient's physician adjusting medications and the patient requires additional blood glucose testing during this time?**
□ Yes □ No	**Is the patient's physician adjusting MNT (medical nutritional therapy) and the patient requires additional blood glucose testing during this time?**
□ Yes □ No	**Does the patient require additional testing due to fluctuations in blood glucose due to physical activity or exercise?**
□ Yes □ No	**Are there other circumstances where the prescribing physician confirms the patient requires a greater quantity because of more frequent blood glucose testing?** *If yes, list circumstance:*

Provider Signature: _____ **Date:** _____