

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: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 for a list of preferred alternatives**

Member First name:	Member Last name:	Member DOB:
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**Clinical and Drug Specific Information**

**Preferred Test Strips/Meters Include:**

<u>OneTouch:</u>	<u>Phone Number</u>	<u>Website</u>
Ultra and Verio	1-800-285-9814	<a href="http://www.onetouch.orderpoints.com">www.onetouch.orderpoints.com</a>
***Preferred meters can be obtained directly from the manufacturer (please see contact info above)***		

**ALL REQUESTS**

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient have a history of failure, contraindication, or intolerance to <b>BOTH</b> preferred test strip products: OneTouch Ultra and OneTouch Verio?</b> <i>(If yes, complete Section D above)</i>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient on an insulin pump?</b>

**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.*

<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient insulin dependent or pregnant?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>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)?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient experiencing postprandial (after-meal) hyperglycemia and needs additional postprandial testing in addition to fasting blood glucose testing?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient's physician adjusting medications and the patient requires additional blood glucose testing during this time?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Is the patient's physician adjusting MNT (medical nutritional therapy) and the patient requires additional blood glucose testing during this time?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Does the patient require additional testing due to fluctuations in blood glucose due to physical activity/exercise?</b>
<input type="checkbox"/> Yes <input type="checkbox"/> No	<b>Are there other circumstances where the prescribing physician confirms the patient requires a greater quantity because of more frequent blood glucose testing?</b> <i>If yes, list circumstance:</i>

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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