

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:
NPI #:	Phone:	Fax: 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	www.onetouch.orderpoints.com
Preferred meters can be obtained directly from the manufacturer (please see contact info above)		

- Does the patient have a history of failure, contraindication, or intolerance to **BOTH** of the following preferred test strip products: Yes No (If yes, complete Section D above with test strip information, including frequency, date of trial and reason for discontinuation) **OneTouch Ultra** **OneTouch Verio**

- Is the patient on an insulin pump? Yes No

- Is the patient insulin dependent or pregnant? Yes No

Requests for Quality Limitations: *(Quantity Limit: Non-Insulin Dependent: 180 strips/90 days, Insulin Dependent: 180 strips/month)*

- 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

- Does the patient meet any of the following: Yes No (check all that apply)

- Patient is experiencing postprandial (after-meal) hyperglycemia and needs additional postprandial testing in addition to fasting blood glucose testing
- Patient's diabetic medication is being adjusted and the patient requires additional testing during this time
- Patients' medical nutrition therapy (MNT) is being adjusted and the patient requires additional testing during this time
- Patient's is having fluctuations in blood glucose due to physical activity/exercise and required additional testing
- None of the above

- Are there other circumstances where the prescribing physician confirms the patient requires a greater quantity because of more frequent blood glucose testing? Yes No If yes, please explain: _____

Provider Signature: _____ **Date:** _____

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