



BLOOD GLUCOSE METERS & TEST STRIPS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Blood Glucose Meters and Test Strips** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.pa.gov/agencies/dhs/resources/for-providers/ma-for-providers/pharmacy-services.html>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:			Specialty:	
Contact's phone number:			NPI:	State license #:
Facility contact/phone:			Street address:	
Beneficiary name:			City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:	

CLINICAL INFORMATION

Product requested:	<input type="checkbox"/> Blood glucose meter (<i>name</i>):		
	<input type="checkbox"/> Blood glucose test strips (<i>name</i>):		
Testing frequency:	Quantity:	Refills:	
Is the beneficiary pregnant?	<input type="checkbox"/> Yes – <i>Submit documentation.</i>		<input type="checkbox"/> No
Does the beneficiary use insulin?	<input type="checkbox"/> Yes – <i>Submit documentation.</i>		<input type="checkbox"/> No
Does the beneficiary use an insulin pump?	<input type="checkbox"/> Yes – <i>Submit documentation.</i>		<input type="checkbox"/> No
<p>For NON-PREFERRED meters/test strips: Did the beneficiary try the preferred meters/test strips from both preferred manufacturers? <i>Indicate meters tried and submit supporting documentation. Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Blood Glucose Meters and Test Strips.</i></p> <p><input type="checkbox"/> Accu-Chek Guide/Guide Me (Roche): _____</p> <p><input type="checkbox"/> TrueMetrix (Trividia): _____</p>			
<p>For NON-PREFERRED meters/test strips: Why can't the beneficiary use the preferred meters/test strips? <i>Document reason(s) in the space provided and submit supporting documentation.</i></p> 			
<p>For requests that EXCEED THE QUANTITY LIMITS of 1 meter per 365 days and/or 3 strips per day, <i>Document reason(s) for exceeding the quantity limits in the space provided and submit supporting documentation, including testing logs.</i></p> 			

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date:
------------------------------	--------------

Confidentiality Notice: The documents accompanying this telecopy may contain confidential information belonging to the sender. The information is intended only for the use of the individual named above. If you are not the intended beneficiary, you are hereby notified that any disclosure, copying, distribution or taking of any telecopy is strictly prohibited.