Texas | Medicaid

Wellpoint

CONTAINS CONFIDENTIAL PATIENT INFORMATION

Blood Glucose Test Strips and Monitors

Prior Authorization of Benefits (PAB) Form

Complete form in its entirety and fax to:

Prior Authorization of Benefits Center at 844-474-3341.

1. PATIENT INFORMATION

Patient Name: _____

Patient ID #: _____

Patient DOB: _____

Date of Rx: _____

Patient Phone #: _____

Patient Email Address: _____

2. PATIENT INFORMATION

Prescribing Physician: _____

Physician Address: _____

Physician Phone #: _____

Physician Fax #: _____

Physician Specialty: _____

Physician DEA: _____

Physician NPI #: _____

Physician Email Address: _____

3. MEDICATION	4. STRENGTH	5. DIRECTIONS	6. QUANTITY PER 30 DAYS
_____	_____	_____	Specify: _____

7. DIAGNOSIS:

8. APPROVAL CRITERIA: CHECK ALL BOXES THAT APPLY

NOTE: Any areas not filled out are considered not applicable to your patient & MAY AFFECT THE OUTCOME of this request.

☐ Yes ☐ No Patient has tried the preferred blood glucose test strips (True Metrix) or monitor (True Metrix)

☐ Yes ☐ No Patient is unable to use the preferred test strips or monitors for any of the following reasons:

- ☐ Yes ☐ No Manual dexterity impairment
- ☐ Yes ☐ No Visual impairments

Blood Glucose Test Strips Increased Quantity Request:

☐ Yes ☐ No Patient is requesting greater than 100 (or 102 for AccuChek Compact) test strips per 30 days

If yes, please indicate reason:

- ☐ Patient has gestational diabetes
- ☐ Patient is currently using insulin
- ☐ Physician or diabetes educator has indicated that the member requires greater than 100 (or 102 for AccuChek Compact) test strips per 30 days

9. PHYSICIAN SIGNATURE

_____ _____

Prescriber or Authorized Signature Date

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

provider.wellpoint.com/tx/

Medicaid services provided by Wellpoint Insurance Company to members in the Medicaid Rural Service Area and the STAR Kids program and Wellpoint Texas, Inc. to all other Wellpoint members in Texas.

Providers: You are required to return, destroy or further protect any PHI received on this document pertaining to members whom you are not currently treating. Providers are required to immediately destroy any such PHI or safeguard the PHI for as long as it is retained. In no event are you permitted to use or re-disclose such PHI.