



**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**

**2. PATIENT INFORMATION**

Patient Name: _____ Patient ID #: _____ Patient DOB: _____ Date of Rx: _____ Patient Phone #: _____ Patient Email Address: _____	Prescribing Physician: _____ Physician Address: _____ Physician Phone #: _____ Physician Fax #: _____ Physician Specialty: _____ Physician DEA: _____ Physician NPI #: _____ Physician Email Address: _____
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**3. MEDICATION**

**4. STRENGTH**

**5. DIRECTIONS**

**6. QUANTITY PER 30 DAYS**

_____	_____	_____	Specify: _____
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**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
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*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.*

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Page 2 of 2

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.