1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545
Prior Authorization Fax: 1-844-712-8129

Diabetic Test Strips Prior Authorization Request Form (Page 1 of 2)

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the requested product below:
❑ Blood Glucose Meter (Please provide the brand name:_____)
❑ Test Strips (Please provide the brand name:_____)

Select the products the patient has a history of:
❑ Accu-Chek test strips (e.g., Accu-Chek Aviva, Accu-Chek Compact)
❑ OneTouch test strips (e.g., OneTouch Basic, OneTouch Sure Step)

Clinical information:
Is the requested test strip the only product that will interface with the patient's insulin pump? ❑ **Yes** ❑ **No**

For Abbott test strips and meters, answer the following:
Is the patient currently using an OmniPod insulin pump? ❑ **Yes** ❑ **No**
Is the patient requesting only FreeStyle test strips? ❑ **Yes** ❑ **No**
Is the patient requesting FreeStyle Insulinx, FreeStyle Lite, FreeStyle Precision Neo, or Precision Xtra test strips? ❑ **Yes** ❑ **No**

For Bayer test strips and meters, answer the following:
Is the patient currently using a MiniMed insulin pump? ❑ **Yes** ❑ **No**
Is the patient requesting only Contour Next test strips? ❑ **Yes** ❑ **No**
Is the patient requesting Breeze2 or Contour test strips? ❑ **Yes** ❑ **No**

For Roche test strips and meters, answer the following:
Is the patient currently using an Accu-Chek Combo insulin pump? ❑ **Yes** ❑ **No**
Is the patient requesting only Accu-Chek Aviva Plus test strips? ❑ **Yes** ❑ **No**
Is the patient requesting Accu-Chek Compact, Accu-Chek Compact Plus, or Accu-Chek Smartview test strips? ❑ **Yes** ❑ **No**

Medical records:
Will medical records documenting a physical or mental limitation that makes utilization of one of the Lifescan diabetic meter/test strip products unsafe, inaccurate or otherwise not feasible (e.g., manual dexterity) be submitted to *ProAct*® with this form? ❑ **Yes** ❑ **No**

[Lifescan diabetic meter/test strip products include: One Touch UltraMini meter (One Touch Ultra test strips), One Touch Ultra 2 meter (One Touch Ultra test strips*), One Touch Verio meter (One Touch Verio test strips),One Touch Verio IQ meter (One Touch Verio test strips) and One Touch Verio Sync meter (One Touch Verio test strips)]*
Please note: Chart documentation of the above is required to be submitted along with this fax

Quantity limit requests:
What is the quantity requested per month? _____

Does the physician confirm that the patient requires a greater quantity because of more frequent blood glucose testing (e.g., patients on intravenous insulin infusions)? ❑ **Yes** ❑ **No**

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Diabetic Test Strips Prior Authorization Request Form (Page 2 of 2)

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ **Date:** _____

PROACT INTERNAL USE ONLY:					
Clinical Review Decision					
	Approved, through				
	Denied (documentation attached, if necessary)				
Tracking:					
1st Attempt		2nd Attempt		Letter Mailed:	