CarePlus HEALTH PLANS

PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Diabetic Meters & Test Strips - PA - 12

Phone: 1-866-315-7587 Fax to: 1-800-310-9071

CarePlus manages the pharmacy drug benefit for your patient. Certain requests for prior authorization require additional information from the prescriber. Please provide the following information and fax this form to the number listed above. Information left blank or illegible may delay the review process.

Patient name:	**Prescriber name:**	
Member/subscriber number:	Fax:	Phone:
Patient date of birth:	Office contact:	
Group number:	NPI:	Tax ID:
Address:	Address:	
City, state ZIP:	City, state ZIP:	
	Specialty/facility name (if applicable):	

Drug name:	☐ Expedited/exigent/urgent
Directions/SIG:	By checking this box, I certify an expedited/exigent/urgent review is required. The member has a health condition that may seriously jeopardize his/her life or ability to regain maximum function. **(Please include explanation of exigency in the space below.)**
Quantity:	

Is this a proactive request for a new plan year? Yes____ No____ If yes, please provide plan year:_____

(Please note: All reviews will be processed with generic equivalents for brand drugs whenever possible.)

Please attach pertinent medical history or information for this patient that may support approval and sign this form.

Q1. Please provide diagnosis: *
Q2. Please provide J-Code, if applicable:
Q3. Please provide ICD Diagnostic Codes:
Q4. Is the request for a reauthorization? ☐ Yes ☐ No
Q5. Is the patient currently stable on therapy? ☐ Yes ☐ No
Q6. Is the requested non-preferred meter and/or test strips for self-monitoring of blood glucose (i.e. fingerstick testing) deemed medically necessary for the patient? ☐ Yes ☐ No

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Q7. If yes, please indicate which of the following medical necessessity reasons apply:

☐ Using an insulin pump that is only compatible with the requested non-preferred meter and/or test strips

☐ Using a non-preferred meter and/or test strips adapted to a dexterity impairment (e.g. large buttons for severe arthritis)

☐ Using a non-preferred meter and/or test strips adapted to a visual impairment (e.g. talking meter)

☐ Other

Q8. If other, please specify:

Q9. Please provide previous therapies used with start/end dates and reason for discontinuing drug(s) that would be pertinent to the review of the drug requested:

Prescriber signature

Date

