AmeriHealth

Prior Authorization Form

DIABETIC TEST STRIPS

ONLY COMPLETED REQUESTS WILL BE REVIEWED

Drug Requested: *(check one)*
- ☐ **LifeScan One Touch® (*specify brand*)** _____
- ☐ **Accu-Check® (*specify brand*)** _____
- ☐ **Other** _____

Date: _____ Patient ID#: _____ DOB: _____

Patient Name: _____ Provider NPI: _____

Prescribing Physician: _____ Office Contact: _____

Office Fax #: _____ Office Phone: _____

ONLY COMPLETED REQUESTS WILL BE REVIEWED

1. MEDICATION HISTORY (Please list any previous or current therapy related to the diagnosis, using drug names and dates)

A. Has the patient had a 30 day trial and failure or contraindication to ONE test strip from EACH of the following preferred manufacturers? (MUST *check all that apply below*) ☐ **YES** ☐ **NO**

I) BAYER:

☐ Ascensia Auto disc ☐ Ascensia Breeze 2 ☐ Ascensia Contour ☐ Ascensia ELITE

II) ABBOTT:

☐ Freestyle Lite ☐ FreeStyle ☐ Precision XTRA

B. Does the patient have significant visual impairment that requires the use of an audio playback of testing results? ☐ **YES** ☐ **NO**

C. Does the patient currently use an insulin pump that employs radio frequency technology? ☐ **YES** ☐ **NO**

Please list any other strips that the patient has tried:

Drug Name	Date	Duration

Please add any other supporting medical information that may be useful in the decision-making process:

_____

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FAX TO (888) 671-5285. YOUR OFFICE WILL RECEIVE A RESPONSE VIA FAX OR MAIL.

Internal use only **Coverage effective date / /**

Document #_____ Processor Initials_____ Date_____

M F Rx coverage Y N STANDARD - SELECT LOB_____

Previous Auth Y N **Approved** **Reviewer Initials**_____ Date_____

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