



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:

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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 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:

Table with 3 columns: Drug Name, Date, Duration

Please add any other supporting medical information that may be useful in the decision-making process including contraindications to medications related to the diagnosis:

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

Internal use only
Document #
Coverage effective date / /
Processor Initials Date
M F Rx coverage Y N STANDARD - SELECT LOB
Previous Auth Y N Approved Reviewer Initials Date