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 to ONE test strip from <u>EACH</u> of the following preferred manufacturers? (<u>MUST</u> *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 including contraindications to medications related to the diagnosis:

_____

_____

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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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