CareSource®
P.O. Box 8738
Dayton, OH 45401-8738

Diabetes Test Strips Prior Authorization Request Form

PHARMACY FAX # 866-930-0019

Note: Prior Authorization Requests without clinical justification or previous products noted will be considered INCOMPLETE; illegible or incomplete forms will be returned.

PATIENT INFORMATION

Patient Name			Date
CareSource ID	DOB	Gender: M/F	
Medication Allergies			
Pharmacy	Pharmacy Phone		

PROVIDER INFORMATION

Prescriber Name	NPI #	DEA #
Prescriber Specialty	Prescriber Address	
Office Fax	Phone	Office Contact Name

PRODUCT REQUESTED

Non-preferred product requested	☐ Blood glucose meter (*name*)		
	☐ Blood glucose test strips (*name*)		
Directions		Quantity	Refills

CLINICAL JUSTIFICATION*

1. Did the patient try all of the preferred products from the preferred manufacturer? *Check all that apply and submit supporting documentation.*

Freestyle Meters	**Freestyle Test Strips**	**Other Meters**	**Other Test Strips**
☐ Freestyle Lite	☐ Freestyle Lite	☐ Precision Xtra	☐ Precision Xtra
☐ Freestyle Freedom Lite	☐ Freestyle Freedom Lite		
☐ Freestyle Insulinx	☐ Freestyle Insulinx		

2. Why can't the patient use any of the preferred blood glucose meters and/or strips? (*Document reason(s) in the space provided and submit supporting documentation.)*

3. **If the request exceeds the quantity limits of 1 meter per 365 days and/or 6 strips per day,** *document reason(s) for exceeding the quantity limits in the space provided and submit supporting documentation.*

Provider Signature	Date

In order to process this request, please complete all boxes completely.

CareSource will review and issue a decision within 24 hours of the original receipt of a pharmacy prior authorization request.

GA-P-0541 DCH approved: 10/25/2018