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

# *Diabetes Testing Supplies Prior Authorization Request Form*

## PHARMACY FAX # 1-866-930-0019

Note: Prior authorization requests without preferred product history or clinical justification will be considered INCOMPLETE; illegible or incomplete forms will be returned.

## PATIENT INFORMATION

**Non-Urgent** ☐ **Urgent** ☐

| | | |
|---|---|---|
| Patient Name | | Date |
| CareSource ID | Date of Birth | Gender Assigned at Birth: Male/Female |
| Medication Allergies | | |
| Pharmacy | Pharmacy Phone | |

## PROVIDER INFORMATION

| | | |
|---|---|---|
| Prescriber Name | National Provider Identifier (NPI) # | Drug Enforcement Administration (DEA) # |
| Prescriber Specialty | Prescriber Address | |
| Office Fax | Office Phone | Office Contact Name |

## PRODUCT REQUESTED

| | | | |
|---|---|---|---|
| Non-preferred product requested | ☐ Blood glucose meter (*name*) | | |
| | ☐ Blood glucose test strips (*name*) | | |
| Directions for Use | Quantity per Days' Supply | Refills | |

## CLINICAL JUSTIFICATION*

1. Did the patient try all of the products from the preferred manufacturers? *Check all that apply:*

| Accu-Chek Meters | Accu-Chek Test Strips | True Metrix Meters | True Metrix Test Strips |
|---|---|---|---|
| O Accu-Chek Guide Kit | O Accu-Chek Guide Test Strips | O True Metrix Self Monitoring Blood Glucose System | O True Metrix Test Strips |
| O Accu-Chek Guide Me Kit | | O True Metrix Air Blood Glucose System | O ReliOn Rx TMX Test Strips |
| | | O ReliOn Rx TMX Blood Glucose System | |

Note the product trial dates: _____

2. What is the reason the patient cannot use a preferred blood glucose meter and/or strips? (*Document reason(s) in the space provided and submit supporting documentation.)*

3. **If the request exceeds the quantity limits of one meter per 365 days and/or 50 strips per month,** *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 and submit supporting documentation.***

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