NON-PREFERRED GLUCOSE TEST STRIPS/DISKS AND METERS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for prior authorization consideration. For formulary information and to download additional forms, please visit https://www.bcbstx.com/provider/medicaid/star_kids_prior_auth.html

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBSTX ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis – ICD code plus description:

Medication Requested: Strength:

Dosing Schedule: Quantity per Month:

1. Has the patient tried a preferred glucose test strip/disk or meter? ☐ Yes ☐ No
   If yes, please provide date(s) of trial(s):_____
2. Does the patient have limitations of use of the preferred glucose test/strip/disk or meter? ☐ Yes ☐ No
   If yes, please explain:_____
3. Is the request for a non-preferred glucose test strip/disk or meter for use with an insulin pump? ☐ Yes ☐ No
4. Does the patient use an insulin pump that is not accommodated with a preferred glucose test strip/disk or meter? ☐ Yes ☐ No
5. Does the patient have a condition that makes him/her unable to enter blood glucose levels into his/her insulin pump? ☐ Yes ☐ No
6. Does the patient have a disability which requires a non-preferred glucose test strip/disk and meter? ☐ Yes ☐ No
7. Please list the medications the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if brand name, generic, extended-release products, or OTC products)**:**

   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
8. Please list all reasons for selecting the **requested medication** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions.) _____
   _____
9. Please list all other medications the patient is **currently taking** for treatment of this diagnosis._____
   _____

Prescriber or Authorized Signature: _____ **Date:** _____

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

Please fax or mail this form to:
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TOLL FREE

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