maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Diabetic Testing Supplies – Test Strips QL

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	Is the quantity requested GREATER THAN 150 test strips per 30 days? If yes, please document the quantity requested: _____ [If no, no further questions.]	Yes	No
2	Is the patient greater than 12 years of age? [If no, no further questions.]	Yes	No
3	Has the patient been newly diagnosed with diabetes or with gestational diabetes? [If yes, no further questions.]	Yes	No

If you have any questions, call: 1-888-258-8250

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4	Is the patient on an insulin pump? [If yes, no further questions.]	Yes	No
5	Is the patient on high intensity insulin therapy with documentation of need to routinely test more than 4-5 times daily?	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

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