GLUCOSE AGENTS
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/rx_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. Is the patient currently treated with the requested product? ☐ Yes ☐ No
   If yes, when was treatment with the requested product started? _____
2. Is the patient currently being treated with a diabetes agent? ☐ Yes ☐ No
   If yes, please specify agent: _____
3. Is the patient currently treated with any agents that can interfere with blood sugar levels? **Check all that apply.**
   - ☐ Prenatal vitamins
   - ☐ Oral steroids – e.g. hydrocortisone, methylprednisolone, prednisone
   - ☐ Antipsychotics – e.g. risperidone, quetiapine, olanzapine
   - ☐ Oral oncology medications – e.g. Afinitor, Lenvima, Gleevec, Tarceva
   - ☐ Thyroid medications- e.g. Synthroid, levothyroxine, methimazole, propylthiouracil
   - ☐ Other, please specify: _____
4. Does the patient have gestational diabetes? ☐ Yes ☐ No
   If yes, when is the expected due date? _____
5. Does the patient have prediabetes or diabetes requiring blood sugar monitoring? ☐ Yes ☐ No
   If yes, does the patient have one of the following (measured within the past 6 months) ☐ Yes ☐ No
   a. HbA1C ≥ 5.7%
   b. Fasting plasma glucose ≥ 100 mg/dL
   c. Oral Glucose Intolerance Test ≥ 140 mg/dL
   ****Lab reports are required****
6. **The preferred products are made by Lifescan/OneTouch.** Does the patient have limitations of use of the preferred glucose test/strip/disk or meter? ☐ Yes ☐ No
   If yes, please explain: _____
7. Is the request for a non-preferred glucose test strip/disk or meter for use with an insulin pump? ☐ Yes ☐ No
   If yes, does the insulin pump or continuous glucose monitoring (CGM) device not accommodate a preferred glucose test strip/disk or meter? ☐ Yes ☐ No
8. Does the patient have a condition that prevents them from entering blood sugar levels into their pump? ☐ Yes ☐ No

Please continue to Page 2.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

9. Does the patient have a disability which requires a non-preferred glucose test strip/disk and meter? ..... ☐ Yes ☐ No

10. Please list all reasons for selecting the requested **agent** over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives). _____

_____

11. Please list all other agents the patient is **currently taking for treatment of this diagnosis.** _____

_____

12. Please list the agents 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): _____

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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Eagan, Minnesota 55121

TOLL FREE

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