pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

BLOOD GLUCOSE METERS & TEST STRIPS PRIOR AUTHORIZATION FORM

Prior authorization guidelines for **Blood Glucose Meters and Test Strips** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx

☐New request ☐Renewal request	# of pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
Facility contact/phone:		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product requested:	☐Blood glucose meter (*name*):		
	☐Blood glucose test strips (*name*):		
Testing frequency:		Quantity:	Refills:
Is the beneficiary pregnant?		☐Yes – *Submit documentation.*	☐No
Does the beneficiary use insulin?		☐Yes – *Submit documentation.*	☐No
Does the beneficiary use an insulin pump?		☐Yes – *Submit documentation.*	☐No

For non-preferred meters/test strips: Did the beneficiary try the preferred meters/test strips from both of the preferred manufacturers? *Indicate meters tried and submit supporting documentation. Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Blood Glucose Meters and Test Strips.*

☐Ascencia/Contour: _____

☐Lifescan/One Touch: _____

For non-preferred meters/test strips: Why can't the beneficiary use the preferred meters/test strips? *Document reason(s) in the space provided and submit supporting documentation.*

For requests that exceed the quantity limits of 1 meter per 365 days and/or 3 strips per day, *Document reason(s) for exceeding the quantity limits in the space provided and submit supporting documentation, including testing logs.*

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	**Date:**