UnitedHealthcare Community Plan

Test Strips - Washington
Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826.**
This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		

Is the requested medication: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ No If recently discharged, list discharge date: _____

Section B - Provider Information

First Name:		Last Name:		M.D./D.O.
Address:		City:	State:	ZIP code:
NPI #:	Phone:	Fax:	Specialty:	
Office Contact Name / Fax attention to:				

Section C - Medical Information

Medication:	**Strength:**
Directions for use:	**Quantity:**
Diagnosis (Please be specific & provide as much information as possible)**:**	**ICD-10 CODE:**

Is this member pregnant? □ Yes □ No If yes, what is this member's due date? _____

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL for a list of preferred alternatives

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

Preferred Test Strips/Meters Include:

OneTouch:	Phone Number	Website
Ultra and Verio	1-800-285-9814	www.onetouch.orderpoints.com

Preferred meters can be obtained directly from the manufacturer (please see contact info above)

- **Does the patient have a history of failure, contraindication, or intolerance to BOTH of the following preferred test strip products:** □ **Yes** □ **No** (If yes, complete Section D above with test strip information, including frequency, date of trial and reason for discontinuation) □ **OneTouch Ultra** □ **OneTouch Verio**

- **Is the patient on an insulin pump?** □ **Yes** □ **No**

- **Is the patient insulin dependent or pregnant?** □ **Yes** □ **No**

Requests for Quality Limitations: *(Quantity Limit: Non-Insulin Dependent: 180 strips/90 days, Insulin Dependent: 180 strips/month)*

- **Does the physician confirm that the patient requires a greater quantity because of more frequent blood glucose testing (e.g. patient's on intravenous insulin infusions)?** □ **Yes** □ **No**

- **Does the patient meet any of the following:** □ **Yes** □ **No** **(check all that apply)**
  - ____ Patient is experiencing postprandial (after-meal) hyperglycemia and needs additional postprandial testing in addition to fasting blood glucose testing
  - ____ Patient's diabetic medication is being adjusted and the patient requires additional testing during this time
  - ____ Patients' medical nutrition therapy (MNT) is being adjusted and the patient requires additional testing during this time
  - ____ Patient's is having fluctuations in blood glucose due to physical activity/exercise and required additional testing
  - ____ None of the above

- **Are there other circumstances where the prescribing physician confirms the patient requires a greater quantity because of more frequent blood glucose testing?** □ **Yes** □ **No** **If yes, please explain:** _____

_____

Provider Signature: _____ **Date:** _____