UnitedHealthcare Community Plan

Test Strip

PRIOR AUTHORIZATION REQUEST FORM

Complete ENTIRE form and Fax to: 866-940-7328

SECTION A - PATIENT INFORMATION		
Today's Date:	First Name:	Last Name:
Member ID #:	Address:	
City:	State:	Zip:
Phone:	DOB:	Allergies:
Primary Insurance:	Policy #:	Group #:

Is the requested medication NEW ☐ or a CONTINUATION of THERAPY ☐? If so, start date:_____________

Is this patient currently hospitalized? ☐Yes ☐No

SECTION B - PHYSICIAN INFORMATION				
First Name:		Last Name: M.D./D.O.		
Address:		City:	State:	Zip:
Phone:	Fax:	NPI #:	Specialty:	
Office Contact Name / Fax Attention to:				

Test Strip Requested:

Directions for use:

Diagnosis (Please be specific & provide as much information as possible):	**ICD-10 Code:**

Preferred Test Strips / Meters Include: One Touch (Basic, Profile, Sure Step, Ultra) and Accu-Chek (Smart View, Aviva, Aviva Plus, Compact, Comfort Curve, Active

Preferred meters can be obtained directly from the manufacturer:

Roche (877) 411 – 9833 or www.meters.accu-chek.com (group code RXAC10)
Lifescan (800) 285 – 9814 (order code 596UHC100) or www.onetouch.orderpoints.com

For Non-Preferred Test Strips:

- **Is the patient on an insulin pump? YES or NO (Circle Appropriate Answer)**
- **Has the patient tried BOTH an Accu-Chek test strip and a One Touch test strip and they have not met the patient's needs? YES or NO (Circle Appropriate Answer) If yes provide details below:** ___________________________

For Quantity Limitation Requests: (Quantity Limit: 100 Strips per 90 days for patients that do not require insulin or 200 Strips per month for patients that require insulin)

- **Is this patient using insulin? YES or NO (Circle Appropriate Answer)**
- **Does the patient meet any of the following? (Check any that apply)**
  - ______Patient is experiencing after-meal hyperglycemia and needs additional testing after meals.
  - ______Patient's diabetes medication is being adjusted and the patient needs additional testing during this time.
  - ______Patient's medical nutrition therapy (MNT) is being adjusted and the patient needs additional testing during this time.
  - ______The patient is having fluctuations in blood glucose due to physical activity/exercise and required additional testing.
  - ______Patient is pregnant and has gestational diabetes.
  - ______None of the above
- **Is there a reason or special circumstance that the patient requires a greater quantity of test strips? YES or NO**
  Please explain: ___________________________

Physician Signature: ___________________________ **Date:** _______________

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