

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/pharmacy/star-kids-prior-auth>

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:
<p>1. Is the patient currently treated with the requested product? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested product started? _____</p> <p>2. Is the patient currently being treated with a diabetes agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify agent: _____</p> <p>3. Is the patient currently treated with any agents that can interfere with blood sugar levels? Check all that apply.</p> <p><input type="checkbox"/> Prenatal vitamins</p> <p><input type="checkbox"/> Oral steroids – e.g. hydrocortisone, methylprednisolone, prednisone</p> <p><input type="checkbox"/> Antipsychotics – e.g. risperidone, quetiapine, olanzapine</p> <p><input type="checkbox"/> Oral oncology medications – e.g. Afinitor, Lenvima, Gleevec, Tarceva</p> <p><input type="checkbox"/> Thyroid medications- e.g. Synthroid, levothyroxine, methimazole, propylthiouracil</p> <p><input type="checkbox"/> Other, please specify: _____</p> <p>4. Does the patient have gestational diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when is the expected due date? _____</p> <p>5. Does the patient have prediabetes or diabetes requiring blood sugar monitoring?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does the patient have one of the following (measured within the past 6 months) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>a. HbA1C \geq 5.7%</p> <p>b. Fasting plasma glucose \geq 100 mg/dL</p> <p>c. Oral Glucose Intolerance Test \geq 140 mg/dL</p> <p>**Lab reports are required**</p> <p>6. The preferred products are made by Lifescan/OneTouch. Does the patient have limitations of use of the preferred glucose test/strip or meter? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain: _____</p> <p>7. Is the request for a non-preferred glucose test strip or meter for use with an insulin pump? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does the insulin pump or continuous glucose monitoring (CGM) device not accommodate a preferred glucose test strip or meter?..... <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Does the patient have a condition that prevents them from entering blood sugar levels into their pump? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	
Please continue to Page 2.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>9. Does the patient have a disability which requires a non-preferred glucose test strip and meter? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Please list all reasons for selecting the requested agent over alternatives (e.g., contraindications, allergies or history of adverse drug reactions to alternatives). _____ _____</p> <p>11. Please list all other agents the patient is currently taking for treatment of this diagnosis. _____ _____</p> <p>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.)</p> <p>_____ Date(s): _____ _____ Date(s): _____ _____ Date(s): _____ _____ Date(s): _____ _____ Date(s): _____ _____ Date(s): _____</p>			
<p>Prescriber or Authorized Signature: _____ Date: _____</p> <p><i>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.</i></p> <p>Note: Payment is subject to member eligibility. Authorization does not guarantee payment.</p>			
<p>Please fax or mail this form to: Prime Therapeutics LLC, Clinical Review Department 2900 Ames Crossing Road Eagan, Minnesota 55121</p> <p>TOLL FREE</p> <hr style="border: 0; border-top: 1px solid black; margin: 5px 0;"/> <p>Fax: 877.243.6930 Phone: 855.457.1200</p>		<p>CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please notify the sender immediately by telephone at 866.202.3474 and return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>	