Prior Authorization Form

CAREFIRST - ANNE ARUNDEL COUNTY PUBLIC SCHOOLS (AACPS)

Diabetic Test Strips (FA-EXC)*

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-487-9257**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Diabetic Test Strips (FA-EXC)*.

Drug Name (select from list of drugs shown)

Glucose Monitoring Devices Other, Please specify

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name: _____

Physician Phone: _____

Physician Fax: _____

Physician Address: _____

City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Preferred products are available at a lower cost. Can your patient be treated with a preferred product? Available Formulary Alternatives: Accu-Chek and OneTouch products Y N

[NOTE: If yes, provide your patient with a new prescription for the preferred product.]

[If Yes, then no further questions. If No, go to 2.]

2. Is the request for a Contour test strip product? Y N

[If Yes, go to 3. If No, go to 4.]

3.	Are the Contour test strips for use in association with a MiniMed insulin pump or OmniPod Dash insulin pump?	Y N
	[NOTE: If yes, then documentation is required for approval.] Document the insulin pump the patient is using:	
	[No further questions.]	
4.	Is the request for a Freestyle test strip product?	Y N
	[If Yes, go to 5. If No, go to 6.]	
5.	Are the Freestyle test strips for use in association with an OmniPod insulin pump?	Y N
	[No further questions.]	
6.	Does the patient have an insulin pump that is incompatible with an Accu-Chek or OneTouch product?	Y N
	[No further questions.]	

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date