Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

BLOOD GLUCOSE METERS & TEST STRIPS

I. Requirements for Prior Authorization of Blood Glucose Meters and Test Strips

A. Prescriptions That Require Prior Authorization

Prescriptions for Blood Glucose Meters (glucometers) and Test Strips that meet any of the following conditions must be prior authorized:

1. A non-preferred Blood Glucose Meter (glucometer). See the Preferred Drug List (PDL) for the list of preferred Blood Glucose Meters at: https://papdl.com/preferred-drug-list.

2. A non-preferred Blood Glucose Test Strip. See the PDL for the list of preferred Blood Glucose Test Strips at: https://papdl.com/preferred-drug-list.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Blood Glucose Meter or Test Strip, the determination of whether the requested product is medically necessary will take into account whether the beneficiary:

1. For a non-preferred Blood Glucose Meter, has a documented history of trial and failure of the use of the preferred Blood Glucose Meters; **AND**

2. For a non-preferred Blood Glucose Test Strip, has a documented history of trial and failure of the use of the preferred Blood Glucose Test Strips that correspond with the preferred Blood Glucose Meters

   NOTE: If the beneficiary does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Blood Glucose Meter or Test Strip. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

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BLOOD GLUCOSE METERS & TEST STRIPS PRIOR AUTHORIZATION FORM

☐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:
Medication will be billed via: ☐ Pharmacy ☐ Medical (Jcode:)		Place of Service: ☐ Hospital ☐ Provider's Office ☐ Home ☐ Other	

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, *Document reason(s) for exceeding the quantity limits in the space provided and submit supporting documentation, including testing logs.*

PLEASE FAX COMPLETED FORM TO HIGHMARK WHOLECARE – PHARMACY DIVISION

Prescriber Signature:	Date: