DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
F-00239 (12/2013)

STATE OF WISCONSIN
DHS 107.10(2), 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR BLOOD GLUCOSE METERS AND TEST STRIPS

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Blood Glucose Meters and Test Strips Completion Instructions, F-00239A. Providers may refer to the Forms page of the ForwardHealth Portal at *https://www.forwardhealth.wi.gov/WIPortal/subsystem/publications/forwardhealthcommunications.aspx?panel=Forms* for the completion instructions.

Pharmacy providers are required to have a completed Prior Authorization Drug Attachment for Blood Glucose Meters and Test Strips form signed by the prescriber before submitting a prior authorization (PA) request on the Portal, by fax, or by mail. Providers may call Provider Services at 800-947-9627 with questions.

SECTION I — MEMBER INFORMATION

1. Name — Member (Last, First, Middle Initial)

2. Member Identification Number

3. Date of Birth

SECTION II — PRESCRIPTION INFORMATION

4. Product Name

5. Date Prescription Written

6. Refills

7. Directions for Use

8. Name — Prescriber

9. National Provider Identifier (NPI) — Prescriber

10. Address — Prescriber (Street, City, State, ZIP+4 Code)

11. Telephone Number — Prescriber

SECTION III — CLINICAL INFORMATION

12. Diagnosis Code and Description

13. Is the member using an insulin pump? ❑ Yes ❑ No

If yes, indicate the manufacturer or type of insulin pump.

14. Does the member have a medical condition that requires the use of a specialized meter (e.g., visually impaired)? ❑ Yes ❑ No

If yes, indicate the medical condition the member has that requires the use of a specialized meter in the space provided.

Continued

SECTION III — CLINICAL INFORMATION (Continued)

15. Is the member unable to use a product from each of the preferred manufacturers? ❑ Yes ❑ No

If yes, specifically address why the member is unable to use a product from each of the preferred manufacturers. Documentation of previous preferred products attempted and detailed reasons why they were discontinued or unable to be used is required.

SECTION IV — AUTHORIZED SIGNATURE

16. **SIGNATURE —** Prescriber	17. Date Signed

SECTION V — ADDITIONAL INFORMATION

18. Include any additional information in the space below. Additional diagnostic and clinical information explaining the need for the product requested may be included here.

Reset Form