DEPARTMENT OF HEALTH SERVICES
Division of Health Care Access and Accountability
F-00239 (04/10)

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

FORWARDHEALTH

PRIOR AUTHORIZATION DRUG ATTACHMENT FOR DIABETIC SUPPLIES

Instructions: Type or print clearly. Before completing this form, read the Prior Authorization Drug Attachment for Diabetic Supplies Completion Instructions, F-00239A. Providers may refer to the Forms page of the ForwardHealth Portal at *www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/provider/forms/index.htm.spage* for the completion instructions.

SECTION I — MEMBER INFORMATION

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

2. Member Identification Number

3. Date of Birth

SECTION II — PRESCRIBER INFORMATION

4. Name — Prescriber

5. Prescriber National Provider Identifier

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

7. Telephone Number — Prescriber

SECTION III — DIABETIC SUPPLY INFORMATION

8. Name of Non-preferred Meter

9. Name of Non-preferred Test Strips

SECTION IV— CLINICAL INFORMATION

10. Diagnosis Code and Description

11. Does the member have a diagnosis of Type I diabetes? ❑ Yes ❑ No

12. Does the member have a diagnosis of Type II diabetes? ❑ Yes ❑ No

13. Does the member have a diagnosis of gestational diabetes? ❑ Yes ❑ No

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

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

15. Is the member using a continuous glucose monitoring system? ❑ Yes ❑ No

If yes, indicate the manufacturer or type of continuous glucose monitoring system.

16. 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 condition in the space provided.

Continued

SECTION IV — CLINICAL INFORMATION (Continued)

17. Has the member tried and failed on a product from each of the preferred manufacturers? ❑ Yes ❑ No

If yes, indicate each product name, dates used, and the reason for the failure.

	Product Name / Manufacturer	Approximate Dates Used	Reason for Failure
1			
2			
3			
4			
5			

18. Does the member have a medical condition that prevents the use of a preferred manufacturer? ❑ Yes ❑ No

If yes, indicate the reason the member cannot use the preferred manufacturer.

SECTION V — AUTHORIZED SIGNATURE

19. **SIGNATURE —** Prescriber	20. Date Signed

SECTION VI — ADDITIONAL INFORMATION

21. Additional diagnostic and clinical information explaining the need for the diabetic supply requested may be included below.

Reset Form