**DEPARTMENT OF HEALTH SERVICES STATE OF WISCONSIN**

Division of Medicaid Services DHS 107.10(2), 152.06(3)(h), 153.06(3)(g), 154.06(3)(g), Wis. Admin. Code

F-00239 (12/2013)

**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*](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.

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| **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*

**PRIOR AUTHORIZATION DRUG ATTACHMENT FOR BLOOD GLUCOSE METERS AND TEST STRIPS** 2 of 2

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| **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. | |