

Review Request for Glucose Monitoring and Related Supplies

Please fax the completed form to **1-800-823-5520**.

If you have questions, call **1-866-902-1689** during regular business hours.

Policy Last Review Date: 8/28/08		Policy Effective Date: 02/26/09		Provider Tool Effective Date: 02/26/09	
Member Name:			Date of Birth:		
Insurance Identification Number:			Member Phone Number:		
Ordering Provider Name and Specialty:			Provider ID Number:		
Office Address:					
Office Phone Number:			Office Fax Number:		
Rendering Provider Name and Specialty:			Provider ID Number:		
Office Address:					
Office Phone Number:			Office Fax Number:		
Facility Name:			Facility ID Number:		
Facility Address:					
Date/Date Range of Service:			Place of Service: <input type="checkbox"/> Home <input type="checkbox"/> Inpatient		
Service Requested (CPT if known):			<input type="checkbox"/> Outpatient <input type="checkbox"/> Other: _____		
Diagnosis (ICD-9) if known:					

Please check all that apply to the member:

- Request is for an FDA-approved standard blood glucose monitor
- Request is for a Blood glucose monitor with special features to allow easy use for patients with severe visual impairment (20/200 or greater)
- Request is for any of the following supplies:
 - Blood glucose monitoring strips (reagent strips)
 - Lancets, including spring-powered lancets
 - Replacement batteries, calibrator solution/chips
 - Laser lancets
- Request is for intermittent, short-term use of continuous interstitial glucose monitoring device as an adjunct to standard care
- Request is for long-term use of continuous interstitial glucose monitoring device as an adjunct to standard care
- Request is for combination glucose/fructosamine home testing devices
- Request is for software/hardware required for downloading data from glucose monitor to computers
- Request is for home hemoglobin A1c (HbA1c) or other glycosylated serum protein monitors
- Request is for a non-FDA approved glucose monitors, including those using infrared spectroscopy

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- Request is for continuous glucose device (sensor/transmitter) with wireless communication to a compatible external infusion pump (e.g. Paradigm® REAL-Time System)
- Member has received a prior authorization for use of the external insulin infusion pump (If member does not have prior authorization for the use of the external insulin infusion pump, a request will need to be submitted based on Clinical Guideline CG-DME-01)
 - Approval Date: _____
- Member is currently using a functioning continuous glucose monitor
- Member is currently using an external insulin pump without wireless integration capability
 - Name or type of pump: _____
- Request is for equipment upgrades or accessories to integrate, through wireless communication technology, an insulin pump and interstitial glucose monitor
- Other: _____

The member has the following conditions: (check all that apply)

- Member has Type 1 diabetes
- Member has Type 2 diabetes
- Member has gestational diabetes
- Member has diabetes secondary to other conditions
- Member is ≥ 25 years old
- Member is pregnant and monitor will be used during the course of pregnancy
- Member has documented severe visual impairment of 20/200 or greater
- Member has a diagnosis of “impaired glucose tolerance” or “pre-diabetes”
- Member has inadequate glycemic control despite compliance with frequent self-monitoring (at least 4 times per day) and including fasting hyperglycemia (>150 mg/dl) or recurring episodes of severe hypoglycemia (<50 mg/dl). This poor control is in spite of compliance with multiple alterations in self-monitoring and insulin administration regimens to optimize care.
- Member is receiving insulin injections 3 or more times per day or a medically necessary insulin pump is used for maintenance of blood sugar control.
- Member requires 4 or more fingersticks per day
- Member is under physician supervision, monitoring and interpretation
- Device will be used for 72 consecutive hours on an appropriate, periodic basis
- Member has inadequate glycemic control, demonstrated by HbA1c measurements between 7.0% and 10%, despite (please complete below):
 - Compliance with frequent self-monitoring (at least 4 times per day)
 - Multiple alterations in self-monitoring and insulin administration regimens to optimize care
- Member has recurring episodes of severe hypoglycemia (<50 mg/dl)
- Other: _____

This request is being submitted:

- Pre-Claim
- Post-Claim. If checked, please attach the claim or indicate the claim number: _____
- By checking this box, I attest the information provided is true and accurate to the best of my knowledge. I understand that BlueChoice HealthPlan Medicaid may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Name and Title of Provider or Provider Representative
Completing Form (Please Print)*

Date

***The attestation fields must be completed by a provider or provider representative in order for the tool to be accepted.**