MEDICARE PART B
DIABETIC TESTING SUPPLIES
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for Medicare Part B prospective, concurrent, and retrospective reviews.

Please fax or mail this form to: **TOLL FREE** **Fax: 855-212-8110 Phone: 800-693-6651**	**Prime Therapeutics LLC** **Attn: Medicare Appeals Department** **2900 Ames Crossing Road** **Eagan, MN 55121**

The following documentation is REQUIRED. To submit this form electronically, please click here or go to covermymeds.com.

PATIENT, INSURANCE and PRESCRIBER/CLINIC INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yy):
Insurance ID Number:	Patient Telephone Number:		
Prescriber Name:	Prescriber NPI#:	Specialty:	Clinic Contact Person's Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Clinic Phone #:	Clinic Secure Fax #:	
Is the patient a long term care facility resident? ☐ Yes ☐ No If yes, please provide the LTC facility contact's name, telephone and fax numbers			
LTC Contact Name:	LTC Phone #:	LTC Secure Fax #:	
Patient's Diagnosis (ICD code, plus description):			

Product Requested

Please indicate the testing supplies being requested (check all that apply):

☐ Blood Glucose Meter ☐ Lancets ☐ Test Strips ☐ Other (please provide Brand name): _____

Dosing Schedule: Quantity per Month:

For Benefit Limit Requests:

1. Does the patient require glucose testing more than six times daily (204 strips/month)? ☐ Yes ☐ No
   If yes, please provide an explanation to support daily testing exceeding six times daily. _____

For Non-Preferred Products:

2. Is the patient currently being treated with a diabetes medication? ☐ Yes ☐ No
   If yes, please specify agent: _____
3. Is the patient currently treated with the following medications that can interfere with blood sugar levels? **Check all that apply.**
   - ☐ Prenatal vitamins
   - ☐ Oral steroids – e.g., hydrocortisone, methylprednisolone, prednisone
   - ☐ Antipsychotics – e.g., risperidone, quetiapine, olanzapine
   - ☐ Oral oncology medications – e.g., Afinitor, Lenvima, Gleevec, Tarceva
   - ☐ Thyroid medications- e.g., Synthroid, levothyroxine, methimazole, propylthiouracil
4. Does the patient have gestational diabetes? ☐ Yes ☐ No
5. Does the patient have prediabetes or diabetes? ☐ Yes ☐ No

For ALL Requests

6. Is the patient currently treated with the requested product? ☐ Yes ☐ No
   If yes, please provide the start date: _____
7. Please list all reasons for selecting the **requested product, testing schedule, and quantity** over preferred products (e.g., contraindications, patient specific or product specific challenges, history of failure to the preferred products, lower quantity tried).
   _____
8. Please list all diabetic testing supplies the patient has **tried and failed** for treatment of this diagnosis: **None:** ☐

_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____
_____	Date(s): _____	_____	Date(s): _____