SoonerSelect | aetna

State of Oklahoma
Oklahoma Health Care Authority

Diabetic Supplies Prior Authorization Form

Fax completed prior authorization request form to 888-601-8461 or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at AetnaBetterHealth.com/Oklahoma

Member Name: _____

Member ID: | | | | | | | | | |

Date of Birth: | | / | | / | | | | |

Section I (To Be Completed by Dispensing Pharmacy)

Pharmacy Name: _____ **Pharmacy Phone:** (| | |) | | | - | | | | |

Pharmacy NPI: | | | | | | | | | | | **Pharmacy Fax:** (| | |) | | | - | | | | |

NDC: | | | | | | - | | | | | - | | | **Requested Fill Date:** _____

Product: _____ **Quantity:** _____ **Day Supply:** _____

Prescriber Name: _____ **Prescriber Phone:** (| | |) | | | - | | | | |

Prescriber NPI: | | | | | | | | | | | **Prescriber Fax:** (| | |) | | | - | | | | |

Section II (To Be Completed by Prescriber)

Number of Tests/Day: _____ **If greater than established quantity limit, please provide a detailed description of reason member needs more frequent testing:** _____

_____

_____

Diagnosis (Please check one): **ICD:** _____

☐ **Insulin-Using Diabetes (No Insulin Pump)**

☐ **Insulin-Using Diabetes (Insulin Pump)**

☐ **Non-Insulin Using Diabetes**

☐ **Gestational Diabetes. Please provide estimated date of delivery:** _____

☐ **Other**_____

Has the prescriber verified that the member has been compliant for at least 30 days with testing frequency ordered based on the member's blood glucose log? ☐ **Yes** ☐ **No**

Most recent date of office visit verifying member exhibits medical necessity for requested testing frequency? _____

Prescriber Signature: _____ **Date:** _____