

**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: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Pharmacy NPI: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Pharmacy Fax: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
NDC: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/>	Requested Fill Date: _____
Product: _____	Quantity: _____ Day Supply: _____
Prescriber Name: _____	Prescriber Phone: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Prescriber NPI: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Prescriber Fax: (<input type="text"/> <input type="text"/> <input type="text"/>) <input type="text"/> <input type="text"/> <input type="text"/> - <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

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): Insulin-Using Diabetes (No Insulin Pump) Insulin-Using Diabetes (Insulin Pump) Non-Insulin Using Diabetes Gestational Diabetes. Please provide estimated date of delivery: _____ Other _____ ICD: _____

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: _____

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