## **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.

**Prime Therapeutics LLC** Please fax or mail this form to: **Attn: Medicare Appeals Department TOLL FREE** 2900 Ames Crossing Road Suite 200 Fax: 855-212-8110 Phone: 800-693-6651 Eagan, MN 55121

ATIENT, INSURANCE and PRESC Patient Name (First):	Last:			Today's Date:  M: DOB (mm/dd/yy):		
atient Name (First).	Last.				IVI.	DOB (IIIII/dd/yy).
nsurance ID Number:	'		Pa	atient Telephone I	Number:	
Prescriber Name:	Prescriber NPI#:			Specialty:		Clinic Contact Person's Na
Clinic Name:			CI	inic Address:		
City, State, Zip:		Clinic	Pho	ne #:	Clin	ic Secure Fax #:
s the patient a long term care facility res	ident? 🗌 Yes 📗	No If yes, pleas	e pro	ovide the LTC fac	ility contac	ct's name, telephone and fax nu
.TC Contact Name:		LTC Phone #:			LTC	Secure Fax #:
Patient's Diagnosis (ICD code, plus	description):				·	
Product Requested						
Please indicate the testing supplies			,			
☐ Blood Glucose Meter ☐ Lan	cets	Strips	her	(please provide		
Dosing Schedule:				Quantity	per Mor	nth:
Start Date:	End Date:			Number	of doses	s requested:
Please submit all applicable me For Benefit Limit Requests:  Does the patient require glucose	edical records an	ın six times daily	, (20	ted to the mem	iber's co	ondition and requested dru
Please submit all applicable me For Benefit Limit Requests:  1. Does the patient require glucose If yes, please provide an exp  For Non-Preferred Products: 2. Is the patient currently being tre If yes, please specify agent: B. Is the patient currently treated we prenatal vitamins Oral steroids – e.g., rie Antipsychotics – e.g., rie Oral oncology medications – e.g., rie Thyroid medications – e.g., poes the patient have gestation poes the patient have prediable for ALL Requests  6. Is the patient currently treated we have prediable for ALL Requests	edical records and the testing more that obtained with a diabete with the following much speridone, quetiapons – e.g., Afinitor g., Synthroid, levoual diabetes?tes or diabetes?tith the requested	n six times daily rt daily testing extended in the second responsible to the second responsible	can prec	ted to the mem 4 strips/month) eding six times interfere with b dnisone Tarceva zole, propylthion	daily	Yes
Please submit all applicable meters. Does the patient require glucose If yes, please provide an expersor Non-Preferred Products: Is the patient currently being tree If yes, please specify agent: B. Is the patient currently treated well prenatal vitamins Oral steroids – e.g., please specify agent: Antipsychotics – e.g., ried Oral oncology medications – e.g., ried Oral oncology medications – e.g., provided the patient have prediable for ALL Requests B. Is the patient currently treated well fyes, please provide the star on the provided the star on the patient specific contraindications, patient specific for ALL requests The patient currently treated well fyes, please provide the star on the patient specific for ALL requests all reasons for select contraindications, patient specific	edical records and e testing more that olanation to support atted with a diabete with the following much speridone, quetiapons – e.g., Afinitor g., Synthroid, levoual diabetes?tes or diabetes di	n six times daily rt daily testing extended to the control of the	can precyec, imaginated in the state of the	ted to the mem 4 strips/month) eding six times interfere with b dnisone Tarceva zole, propylthio	daily	Yes
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