BLOOD GLUCOSE METERS & TEST STRIPS PRIOR AUTHORIZATION FORM

(form effective 1/1/2026)

Keystone First
Family of Health Plans

Keystone First: Fax to **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

Keystone First Community HealthChoices: Fax to **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	Facility contact/phone:

BENEFICIARY INFORMATION

Beneficiary name:	Beneficiary ID#:	DOB:	
Street address:			
Apt #:	City/state/zip:	Phone:	Fax:

PHYSICIAN INFORMATION

Physician name:	Physician Tax ID:	
Specialty:	Physician NPI:	
Street address:		
Suite #:	City/state/zip:	
Phone:	Fax:	

FACILITY INFORMATION

Facility NPI:	Facility Tax ID#:	
Street address:		
Suite #:	City/state/zip:	Treatment setting: ☐ Outpatient (home) ☐ Inpatient

CLINICAL INFORMATION

Product requested:	☐ Blood glucose meter (name):			Quantity:
	For DME request only			
	J-code:	Number of units:	Date of service (MM/DD/YYYY):	
	☐ Blood glucose test strips (name):			Quantity:
	For DME request only			
	J-code:	Number of units:	Date of service (MM/DD/YYYY):	
Testing frequency:				Refills:
Diagnosis:				

Is the beneficiary pregnant?	☐ Yes – *Submit documentation* ☐ No
Does the beneficiary use insulin?	☐ Yes – *Submit documentation* ☐ No
Does the beneficiary use an insulin pump?	☐ Yes – *Submit documentation* ☐ No

INITIAL REQUESTS

For NON-PREFERRED meters/test strips: Did the beneficiary try the preferred meters/test strips from both preferred manufacturers? *Indicate meters tried and submit supporting documentation. Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred Blood Glucose Meters and Test Strips.*

☐ Accu-Chek Guide/Guide Me (Roche):_____

☐ TrueMetrix or Trueness (Trividia Health):_____

For NON-PREFERRED meters/test strips: Why can't the beneficiary use the preferred meters/test strips? *Document reason(s) in the space provided and submit supporting documentation.*

INITIAL REQUESTS *(continued)*

For requests that EXCEED THE QUANTITY LIMITS of 1 meter per 365 days and/or 3 strips per day, *Document reason(s) for exceeding the quantity limits in the space provided and submit supporting documentation, including testing logs.*

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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