

TRICARE Prior Authorization Request Form for  
Self-Monitoring Blood Glucose System (SMBGS)  
**Glucose Test Strips**



6087

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

MAIL ORDER and RETAIL	<ul style="list-style-type: none"> <li>The provider may <b>call: 1-866-684-4488</b> or the completed form may be <b>faxed to:</b> <b>1-866-684-4477</b></li> <li>The patient may attach the completed form to the prescription and <b>mail it to: Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954</b> or <b>email the form only to:</b> <b>TPharmPA@express-scripts.com</b></li> </ul>
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**Step 1** Please complete patient and physician information (please print):

<b>1</b>	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID #: _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

**Step 2** Please note: the preferred glucose test strips are **FreeStyle Lite** and **Precision Xtra**. They are covered without prior authorization. You do NOT need to complete this form for coverage of these 2 test strips. All other test strips are subject to prior authorization as provided below.

**Step 3** Please complete the clinical assessment:

1. What is the brand name of the requested glucose test strip?	<b>Test strip:</b>	Proceed to question 2
2. What is the brand and model name of the glucose meter that will be used by the patient?	<b>Meter:</b>	Proceed to question 3
3. Is the patient blind or severely visually impaired?	<input type="checkbox"/> Yes Proceed to question 4	<input type="checkbox"/> No <b>SKIP</b> to question 6
4. Does the patient require a test strip used in a talking meter?	<input type="checkbox"/> Yes Proceed to question 5	<input type="checkbox"/> No <b>SKIP</b> to question 6
5. Which meter will the patient use?	<input type="checkbox"/> Advocate Redicode – Sign and date on page 2 <input type="checkbox"/> Prodigy AutoCode – Sign and date on page 2 <input type="checkbox"/> Prodigy Voice – Sign and date on page 2 <input type="checkbox"/> Other than listed above – Proceed to question 6	
6. Does the patient use an insulin pump?	<input type="checkbox"/> Yes Proceed to question 7	<input type="checkbox"/> No <b>SKIP</b> to question 10
7. What is the brand and model name of the insulin pump that will be used by the patient?	<b>Insulin pump:</b>	Proceed to question 8
8. Does the patient require a test strip that is used in a meter that communicates wirelessly with the insulin pump?	<input type="checkbox"/> Yes Proceed to question 9	<input type="checkbox"/> No <b>SKIP</b> to question 10

*continue to next page*

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9. Which test strip, meter and insulin pump combination will the patient use?

- Contour Next strip + Contour Next Link meter + Medtronic insulin pump
  - Accu-Chek Aviva Plus strip + Accu-Chek Combo meter + Accu-Chek Combo insulin pump
  - FreeStyle strip + FreeStyle meter + OmniPod insulin pump
  - Nova Max strip + Nova Max Link meter + Medtronic insulin pump
  - One Touch Ultra strip + One Touch Ping meter + One Touch Ping insulin pump
  - One Touch Ultra strip + One Touch Ultra Link meter + Medtronic insulin pump
- Sign and date below*
- Other than listed above** – Proceed to question 10

10. Does the patient have a documented physical or mental health disability that requires use of a special strip or meter?

Yes  
Sign and date below

No  
Coverage not approved

**Step 4** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date