PHARMACY COVERAGE GUIDELINES
SECTION: DRUGS

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BLOOD GLUCOSE METER TEST STRIP STEP THERAPY CRITERIA

Coverage for services, procedures, medical devices and drugs are dependent upon benefit eligibility as outlined in the member's specific benefit plan. This Pharmacy Coverage Guideline must be read in its entirety to determine coverage eligibility, if any.

This Pharmacy Coverage Guideline provides information related to coverage determinations only and does not imply that a service or treatment is clinically appropriate or inappropriate. The provider and the member are responsible for all decisions regarding the appropriateness of care. Providers should provide BCBSAZ complete medical rationale when requesting any exceptions to these guidelines.

The section identified as "Description" defines or describes a service, procedure, medical device or drug and is in no way intended as a statement of medical necessity and/or coverage.

The section identified as "Criteria" defines criteria to determine whether a service, procedure, medical device or drug is considered medically necessary or experimental or investigational.

State or federal mandates, e.g., FEP program, may dictate that any drug, device or biological product approved by the U.S. Food and Drug Administration (FDA) may not be considered experimental or investigational and thus the drug, device or biological product may be assessed only on the basis of medical necessity.

Pharmacy Coverage Guidelines are subject to change as new information becomes available.

For purposes of this Pharmacy Coverage Guideline, the terms "experimental" and "investigational" are considered to be interchangeable.

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This Pharmacy Coverage Guideline does not apply to FEP or other states' Blues Plans.

Information about medications that require precertification is available at www.azblue.com/pharmacy.

Some large (100+) benefit plan groups may customize certain benefits, including adding or deleting precertification requirements.

All applicable benefit plan provisions apply, e.g., waiting periods, limitations, exclusions, waivers and benefit maximums.

Precertification for medication(s) or product(s) indicated in this guideline requires completion of the request form in its entirety with the chart notes as documentation. All requested data must be provided. Once completed the form must be signed by the prescribing provider and faxed back to BCBSAZ Pharmacy Management at (602) 864-3126 or emailed to Pharmacyprecert@azblue.com. **Incomplete forms or forms without the chart notes will be returned.**

BLOOD GLUCOSE METER TEST STRIP STEP THERAPY CRITERIA (cont.)

Description:

BCBSAZ covers all Lifescan™ blood glucose meter test strips with applicable quantity level limitations without precertification, all other strips require precertification and approval is based on medical necessity.

Members and their providers are NOT required to participate in the exception precertification program when obtaining BCBSAZ preferred Lifescan blood glucose meter test strips.

For non-preferred blood glucose meter test strips members and their prescribers will be required to participate in the precertification process and the prescriber must complete a precertification request form with information regarding the medical necessity for use of another brand of blood glucose meter test strip.

There are numerous commercially available glucose meters to choose from; they differ in several ways that can include: amount of blood needed for each test, testing speed, overall size and weight of meter, meters ability to store test results in memory, cost of the meter, and cost of the test strips used.

Other meter characteristic may influence choice and includes: whole blood versus plasma glucose concentration results – whole blood is 10-15% lower than plasma (lab results), measurement range, ability to download results to a computer or internet to the provider, ability to average glucose values, whether it also measures ketones, effect of altitude on meter function, ability to use alternate site testing, audio capabilities, backlighting, temperature (high and low) range at which the meter will work, ease of use (number of steps required), other dexterity issues for patients with severe arthritis, need for a user code, when and how to calibrate, display size, meter cleaning requirements, cost/ease of replacement of batteries, and availability of customer support.

Another feature is whether the meter communicates with an insulin pump. Some meters, depending on the glucose reading, will control the functioning of the pump by automatically turning off the pump for 2 hours in the face of a preset low glucose value for individuals with hypoglycemia unawareness or increasing or decreasing insulin delivery based on senor readings.

Criteria:

- **Criteria for initial therapy:** Non-Lifescan FDA-approved blood glucose meter strips is considered ***medically necessary*** and will be approved with medical record documentation of **ONE** of the following criteria:

  1. Member is unable to use the main feature of testing blood sugar on the preferred Lifescan product

  2. Member uses an insulin pump system where the pump is controlled by a non-preferred meter that requires a specific non-Lifescan glucose meter strip
     - Examples include:
       - Accu-Chek Combo System
       - Medtronic MiniMed 530 G, 630G and 670G
       - OmniPod Insulin Management System

  Initial approval duration: 12 months

BLOOD GLUCOSE METER TEST STRIP STEP THERAPY CRITERIA (cont.)

- **Criteria for continuation of coverage (renewal request):** Non-Lifescan FDA-approved blood glucose meter strips is considered ***medically necessary*** and will be approved when of the following criteria is met:

    1. Individual continues to need a non-referred Lifescan product that has additional features not found on preferred product or is unable to use features of the preferred product or is using an insulin pump that is controlled by a non-preferred meter that requires a specific non-Lifescan glucose meter strip

Renewal duration: 12 months

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Fax completed prior authorization request form to 602-864-3126 or email to pharmacyprecert@azblue.com.
Call 866-325-1794 to check the status of a request.
All requested data must be provided. **Incomplete forms or forms without the chart notes will be returned**.
Pharmacy Coverage Guidelines are available at www.azblue.com/pharmacy.

Pharmacy Prior Authorization Request Form

Do not copy for future use. Forms are updated frequently.
REQUIRED: Office notes, labs, and medical testing relevant to the request that show medical justification are required.

Member Information

Member Name (first & last):	Date of Birth:	Gender:	BCBSAZ ID#:
Address:	City:	State:	Zip Code:

Prescribing Provider Information

Provider Name (first & last):	Specialty:	NPI#:	DEA#:
Office Address:	City:	State:	Zip Code:
Office Contact:	Office Phone:		Office Fax:

Dispensing Pharmacy Information

Pharmacy Name:	Pharmacy Phone:	Pharmacy Fax:

Requested Medication Information

Medication Name:	Strength:		Dosage Form:
Directions for Use:	Quantity:	Refills:	Duration of Therapy/Use:

☐ Check if requesting **brand** only ☐ Check if requesting **generic**

☐ Check if requesting continuation of therapy (prior authorization approved by BCBSAZ expired)

Turn-Around Time For Review

☐ Standard ☐ Urgent. Sign here: ________________________________ ☐ Exigent (requires prescriber to include a written statement)

Clinical Information

1. What is the diagnosis? Please specify below.

ICD-10 Code: ____________________ **Diagnosis Description:** ______________________________

2. ☐ Yes ☐ No **Was this medication started on a recent hospital discharge or emergency room visit?**

3. ☐ Yes ☐ No **There is absence of ALL contraindications.**

4. What medication(s) has the individual tried and failed for this diagnosis? Please specify below.
Important note: Samples provided by the provider are not accepted as continuation of therapy or as an adequate trial and failure.

Medication Name, Strength, Frequency	Dates started and stopped or Approximate Duration	Describe response, reason for failure, or allergy

5. Are there any supporting labs or test results? Please specify below.

Date	Test	Value

Pharmacy Prior Authorization Request Form

6. Is there any additional information the prescribing provider feels is important to this review? Please specify below.
For example, explain the negative impact on medical condition, safety issue, reason formulary agent is not suitable to a specific medical condition, expected adverse clinical outcome from use of formulary agent, or reason different dosage form or dose is needed.

Signature affirms that information given on this form is true and accurate and reflects office notes	
Prescribing Provider's Signature:	Date:

Please note: Some medications may require completion of a drug-specific request form.

Incomplete forms or forms without the chart notes will be returned.

Office notes, labs, and medical testing relevant to the request that show medical justification are required.