MEDAVIE BLUE CROSS™

BLOOD GLUCOSE TESTING SUPPLIES REQUEST (TEST STRIPS AND GLUCOSE MONITORING SYSTEMS)

PROCEDURES FOR PRIOR AUTHORIZATION

Completed forms can be faxed in confidence to 1-514-286-8480 for residents of Quebec and 1-844-661-2640 for residents of all other provinces

Upon receipt, this request will be confidentially reviewed according to payment criteria developed by Medavie Blue Cross in consultation with independent health care consultants. In some cases, additional clinical or diagnostic information may be required to process your claim.

If the information on your form is complete, the usual turnaround time for assessment is 7 to 10 working days.

- Please complete the entire form. Incomplete forms can't be processed.
- To be eligible for reimbursement Medavie Blue Cross may require products to be purchased at a designated pharmacy. This authorization may be limited to a specified period or quantity.
- In cases where a request for Prior Authorization is declined, Medavie Blue Cross is denying payment for a product and is not challenging the medical opinion of the physician nor rendering a medical opinion.
- Any costs associated with the completion of this form or obtainment of additional medical information are the responsibility of the member.
- Renewal of the Prior Authorization will be considered by Medavie Blue Cross upon request from the patient/member. The renewal request should include information from the physician supporting continued use of the medication.
- Coverage is continent on your continued status as a Medavie Blue Cross cardholder or beneficiary.

ELIGIBILITY CRITERIA FOR BLOOD GLUCOSE TESTING SUPPLIES

NOTE: Your plan must include coverage for Glucose Monitoring Systems and/or Blood Glucose Test Strips before considering appealing the eligibility criteria outlined below.

- **Glucose Monitoring Systems (Continuous or Flash)**
  Patient must be insulin dependent to be eligible for reimbursement.

- **Blood Glucose test strips**

  The quantity limits are automated at the pharmacy counter based on a patient's drug history as per below:

Diabetes Treatment Category	**Number of test strips per calendar year**
Patients managing diabetes with insulin	3,000 test strips
Patients using blood glucose lowering drugs, excluding insulin	400 test strips
Patients managing diabetes through diet & lifestyle only	200 test strips

For Glucose Monitoring Systems or Blood Glucose test strip, we rely on the patient's drug history to determine eligibility. If the patient's drug coverage is funded through another insurer or government program, please submit this page 2 only and include proof of prescribing or dispensing diabetic drugs to: patientfirstnetwork@medavie.bluecross.ca.

Residents of All Other Provinces
PO BOX 220, MONCTON (NB) E1C 8L3
TEL.: 1-800-667-4511 FAX: 1-844-661-2640

Residents of Quebec
PO BOX 3300, STATION B, MONTREAL (QC) H3B 4Y5
TEL.: 1-888-588-1212 FAX: 1-514-286-8480

FORM-1171 03/23

1. PATIENT INFORMATION

This section is to be completed by the Professional coordinating the request on behalf of the member (PSP, Cancer Care Navigator or Pharmacy)

Decision communication preference: ○ Fax Number: _____ ○ Telephone Number: _____

Name of Program/Pharmacy: _____

Contact Name: _____

2. POLICY INFORMATION

Plan member name: _____ Date of Birth (DD/MM/YYYY): _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Telephone Number: _____

Policy Number: _____ ID Number: _____

3. PATIENT INFORMATION

PART A

Is Patient also the Plan Member? ○ Yes ○ No ☐ Current address same as above (if not, please complete applicable fields below)

Patient name (if not plan member): _____ Date of Birth (DD/MM/YYYY): _____

Address: _____ City: _____

Province: _____ Postal Code: _____ Telephone Number: _____

ID Number: _____

E-mail address of patient or of legal guardian if patient is underage: _____

Do you have valid Medicare coverage in your current province of residence? ○ Yes ○ No

Have you already purchased this prescription? ○ Yes ○ No

Please attach your paid-in-full receipt with this request form. If you have already submitted your receipt to Medavie Blue Cross, please indicate the date of the oldest receipt. Date (DD/MM/YYYY): _____

PART B - Coordination of Benefits

Do you or any dependant have coverage for this drug under any other plan or program? ○ Yes ○ No

If Yes, complete the following:

Policy Number: _____ Carrier: _____

(If applicable, please attach Explanation of Benefits from prior carrier with complete form)

If the patient is a dependent, provide the birth day and month of the cardholder for the other carrier (DD/MM): _____

Public-Funded Program – Have you applied for coverage through a public-funded program? ○ Yes ○ No

If No, please indicate why: _____

PART C - Authorization

I understand that the personal information I have provided herein is collected and used by Medavie Blue Cross to administer the terms of my policy or the group policy of which I am an eligible member, recommend suitable products and services that I am eligible for as a member of a policy, and other applicable purposes, as described in the Medavie Blue Cross Privacy Statement at medaviebc.ca.

Depending on the type of coverage I carry, limited personal information such as claim, health and/or financial related data may be collected from and/or released to following third parties as required for the purposes of administering and managing the benefits outlined in the policy of which I am an eligible member. These third parties may include healthcare providers, other insurance companies, regulatory authorities and investigative bodies, services providers, and/or the cardholder of any contract under which I am a participant.

Where allowed by law, my information may be shared with Medavie Blue Cross employees or service providers in jurisdictions other than where it was collected. If I am a resident of Quebec, this includes transferring or disclosing my personal information to Medavie Blue Cross employees or service providers outside of that province.

I understand that my consent is only valid for the time it is needed to achieve the purposes outlined herein, unless I withdraw it. I understand I may withdraw my consent at any time. However, in some instances doing so may prevent Medavie Blue Cross from providing me with certain products or services that may be useful to me and/or my dependents. This consent complies with federal and provincial privacy laws.

For more details about our information practices, including how your personal information is protected, how to access or correct personal information, or if you have concerns or questions, please see our Medavie Blue Cross Privacy Statement available at medaviebc.ca or call 1-800-667-4511.

Signature of Patient: _____ Date: _____

A photocopy of this authorization shall be as valid as the original.

4. MEDICAL INFORMATION

Name of Patient: _____ Date of Birth (DD/MM/YYYY): _____

Policy Number: _____ ID Number: _____

Please complete this section to appeal the eligibility criteria for Blood Glucose Testing Supplies.

Indicate the type of appeal: ○ Blood Glucose Test Strips quantity eligibility
○ Glucose Monitoring Systems eligibility requirements

Please indicate which (if any) diabetes medication the patient is currently taking:

Category	Product Name	Dosage	Duration of Treatment	Response to Treatment or Contraindication

1. Please indicate the Patient's diagnosis: ○ Type 1 Diabetes ○ Type 2 Diabetes ○ Gestational Diabetes
   If this request is regarding Blood Glucose Test Strips:
   Please indicate how many additional test strips are being requested for this Patient:
2. Please confirm if the patient:
   - Has not attained the glycemic targets determined by their physician for 3 months or more? ○ Yes ○ No
   - Has an acute illness or a comorbidity or underwent a medical or surgical intervention that could have an impact on the person's glycemic control? ○ Yes ○ No
   - Is starting a new pharmacotherapy known for its hypoglycemic or hyperglycemic effects? ○ Yes ○ No
   - Has an occupation that requires, according to physician that a tighter glycemic control for their safety and that of the public (ie: pilot, aerial control, etc.) ○ Yes ○ No
   - Has Type 2 diabetes, is not undergoing insulin therapy and is planning to become pregnant? ○ Yes ○ No
   - Is suffering from a pancreas anomaly? ○ Yes ○ No
3. Are there any exceptional circumstances outside of our eligibility criteria necessitating more frequent testing? ○ Yes ○ No
   If yes, please provide an explanation:

5. PHYSICIAN / PHARMACIST STATEMENT

Physician/Pharmacist Name: _____ Speciality: _____

Telephone Number: _____ Fax Number: _____

Physician/Pharmacist Signature: _____ Date (DD/MM/YYYY): _____