

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 – <i>Submit documentation</i> ☐ No	
Does the beneficiary use insulin?		☐ Yes – <i>Submit documentation</i> ☐ No	
Does the beneficiary use an insulin pump?		☐ Yes – <i>Submit documentation</i> ☐ 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 Truiness (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.

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION

Date:

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