PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

ADDITIONAL BLOOD GLUCOSE TEST STRIPS REQUEST FORM

⊘ PLEASE DO NOT STAPLE

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2689 | Toll-free fax: 1 844 419-2689 | pac.bluecross.ca

HOW TO COMPLETE THIS FORM:
PLAN MEMBERS — Please complete RED portions of this form.
PRESCRIBERS — Please complete BLACK portions of this form.

Don't forget to sign *Part 8 — Member Consent and Declaration* before you submit your claim.

The patient is responsible for any fees charged by the physician for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.

Completion of this form does NOT imply approval for this additional Blood Glucose Test Strips. Coverage is based on the provisions of your Extended Health Care plan and Pacific Blue Cross qualification criteria.

PART 1 — PLAN MEMBER TO COMPLETE

Plan member's name	Patient's name (if different than Plan member's name)			
Patient's birthdate (mm-dd-yyyy)	Policy number	ID number		
Street address	City	Province	Postal code	Daytime phone number (10 digits)

PART 2 — PRESCRIBER TO COMPLETE

Prescriber's name	College ID	Phone number (10 digits)	Fax number (10 digits)
Street address	City	Province	Postal code

Prescriber's area of specialty: ☐ Endocrinologist ☐ DEC Clinician ☐ Other: _____

I certify the medical information provided is accurate and current:

Prescriber's signature **X**	Date (mm-dd-yyyy)

PART 3 — TREATMENT CATEGORY

IMPORTANT NOTE: Approvals through this Prior Authorization request form are limited to a maximum of 100 additional strips per calendar year. Patients taking insulin are not eligible for coverage of 100 additional strips using this form.

Patient is currently:
☐ Managing diabetes through diet/lifestyle
☐ Managing diabetes with anti-diabetic drugs with a **lower** risk of causing hypoglycemia
☐ Managing diabetes with anti-diabetic drugs with a **higher** risk of causing hypoglycemia

PART 4 — PATIENT INFORMATION (to be completed by prescriber)

☐ Patient has PharmaCare Special Authority approval for 100 additional blood glucose test strips (attach copy of approval), OR
☐ Patient has diabetes, is not on insulin, and is experiencing at least one of the following:
- ☐ Not meeting glycemic targets, as determined by physician, for 3 months or more.
- ☐ Acute illness or co-morbidities that may impact blood glucose control.
- ☐ Changes in drug therapy that may impact blood glucose control (e.g. starting or stopping hypo or hyperglycemic inducing medications, drug-to-drug or drug-to-disease interactions).
- ☐ Occupations where hypoglycemia presents a significant safety risk (e.g., pilots, air traffic controllers, commercial drivers, etc.).
- ☐ Gestational Diabetes

PART 5 — CURRENT THERAPY FOR DIABETES

DRUG	STRENGTH	DIRECTIONS	THERAPY DURATION

Place your receipts loose and flat in the envelope — no staples, paperclips or tape. Also no cashier or Interac receipts.

PART 6 — ADDITIONAL INFORMATION

PART 7 — MEMBER CONSENT AND DECLARATION

IMPORTANT: This section must be signed before submitting your form.

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims.

I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan. I authorize my physician to release my personal information to Pacific Blue Cross to obtain approval for prescription benefit.

Member's signature	Date (mm-dd-yyyy)
X	

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