PACIFIC BLUE CROSS®

DO NOT WRITE IN THIS SPACE

FLASH GLUCOSE MONITORING (FLASH) INITIAL/RENEWAL 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 6 — Member Consent and Declaration* before you submit your claim.

The patient is responsible for any fees charged by the prescriber 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 a Flash device or supplies. 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	☐ Other insurance coverage

Street address	City	Province	Postal code	Daytime phone number (10 digits)

☐ I am aware that if I choose to use the Flash Glucose Monitoring system that I will be limited to a maximum of 100 test strips per calendar year during the time I am using this system.

PART 2 — PRESCRIBER WHO IS MANAGING THE FLASH TO COMPLETE

Prescriber's name	College ID

Street address	City	Province	Postal code

Prescriber's area of specialty: ☐ Endocrinologist ☐ Diabetes specialist ☐ Internal medicine

I certify that I am the primary prescriber in the management of this patient's Flash Glucose Monitoring and that the medical information provided is accurate and current:

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

PART 3 — FLASH REQUEST INFORMATION

Flash make and model requested: Brand: _____ Model #: _____

PART 4 — INITIAL REQUEST (1 YEAR): To be completed by prescriber

In order to be considered for Flash coverage, **ALL** of the following must apply:
☐ Diagnosis of Type 1 or Type 2 diabetes on intensive insulin therapy (basal plus bolus combination therapy)
☐ Patient is 4 years of age or older (if requesting Freestyle Libre 2)
☐ Patient is 18 years of age or older (if requesting Freestyle Libre)
☐ A1C has been checked in the last 6 months and is not in the physician determined optimal range
☐ Patient/Family/Caregiver agrees to comprehensive and age-appropriate diabetes education by an interdisciplinary diabetes healthcare team and commits to regular follow-up

AND at least one of the following criteria must apply:
☐ Hypoglycemia unawareness
☐ Frequent and unpredictable hypoglycemic episodes
☐ Unpredictable swings in blood glucose
☐ At least one functional restriction that inhibits the use of blood glucose test strips
☐ An occupation where hypoglycemia presents a significant safety risk (e.g. pilots, air traffic controllers, commercial drivers)

PART 5 — RENEWAL REQUEST (5 YEAR): To be completed by prescriber

All of the following must apply:
☐ Diagnosis of Type 1 or Type 2 diabetes on intensive insulin therapy (basal plus bolus combination therapy)
☐ Patient/Family/Caregiver agrees to comprehensive and age-appropriate diabetes education by an interdisciplinary diabetes healthcare team and commits to regular follow-up
☐ Patient will benefit from continued use of Flash

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 X	Date (mm-dd-yyyy)

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MAIL YOUR FORM
Pacific Blue Cross
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DROP IT OFF
4250 Canada Way
Burnaby, BC V5G 4W6

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Toll-free: 1 844 419-2689

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