



FLORIDA MEDICAID PRIOR AUTHORIZATION
Non Preferred Diabetic Supply (DSP)

Length of Authorization: 1 Year

Note: Form must be completed in full. An incomplete form may be returned.

Beneficiary's Medicaid ID#

Grid for Beneficiary's Medicaid ID#

Date of Birth (MM/DD/YYYY)

Grid for Date of Birth (MM/DD/YYYY)

Beneficiary's Full Name

Grid for Beneficiary's Full Name

Prescriber's Full Name

Grid for Prescriber's Full Name

Prescriber's NPI

Grid for Prescriber's NPI

Prescriber Phone Number

Grid for Prescriber Phone Number

Prescriber Fax Number

Grid for Prescriber Fax Number

Pharmacy Name

Grid for Pharmacy Name

Pharmacy Medicaid Provider #

Grid for Pharmacy Medicaid Provider #

Pharmacy Phone Number

Grid for Pharmacy Phone Number

Pharmacy Fax Number

Grid for Pharmacy Fax Number

REQUESTED DSP - INFORMATION

Product Name: \_\_\_\_\_

Quantity: \_\_\_\_\_ Refills: \_\_\_\_\_

Directions: \_\_\_\_\_

Fax this form to 1-866-940-7328

Pharmacy PA Call Center: 1-855-258-1593

10.14.2024

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**What is the patient's diagnosis?**

- Diabetes Mellitus Type 1
- Diabetes Mellitus Type 2
- Gestational Diabetes
- History of recurring hypoglycemia
- Other: \_\_\_\_\_

**Is this request for a continuous glucose monitor (CGM)?**       Yes       No

**If yes, is the patient currently receiving insulin?**       Yes       No

**Medical justification is required as to why a preferred product cannot be used for this recipient.**

Prescriber's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**REQUIRED FOR REVIEW: All copies of medical records (e.g., diagnostic evaluations and recent chart notes), and the most recent copies of related labs. The provider must retain copies of all documentation for five years.**

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