Reset Form Print Form

United Healthcare Community Plan

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#

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

Beneficiary's Full Name

Prescriber's Full Name

Prescriber's NPI

Prescriber Phone Number - -

Prescriber Fax Number - -

Pharmacy Name

Pharmacy Medicaid Provider #

Pharmacy Phone Number - -

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.