

Prior Authorization Form

Contour Test Strips (FA-PA)

This fax machine is located in a secure location as required by HIPAA regulations. Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**. Please contact CVS/Caremark at **1-800-294-0536** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Contour Test Strips (FA-PA).

Drug Name (select from list of drugs shown)

Contour Next Test Strips

Contour Test Strips

Quantity

Frequency

Strength

Route of Administration

Expected Length of Therapy

Patient Information

Patient Name: _____
 Patient ID: _____
 Patient Group No.: _____
 Patient DOB: _____
 Patient Phone: _____

Prescribing Physician

Physician Name: _____
 Physician Phone: _____
 Physician Fax: _____
 Physician Address: _____
 City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.	
1. Is the patient using a Medtronic MiniMed 530G or MiniMed Paradigm REAL-Time Revel insulin pump? If yes, please submit documentation including name of insulin pump.	Y N
2. Is the request for Contour or Contour Next test strips for use in association with a Contour LINK or Contour Next LINK Meter?	Y N

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I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date