Rational Drug Therapy Program
West Virginia University School of Pharmacy
On Behalf of the WV Bureau for Medical Services
PO Box 9511 HSCN
Morgantown WV 26506-9511

Requests for Exemption from Criteria
(Please print or type)
FAX, Phone, Mail completed form to:
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Diabetic Supplies Medical Necessity Authorization Form

Patient Name (Last) (First) (MI)	WV Medicaid ID #:	Date of Birth:
Physician Name (Last) (First) (MI)		Phone #
Physician DEA Number		FAX #

All supply quantities that fall outside of Medicaid limitations will require prior authorization from the RDTP.

Item Prescribed	Insulin Dependent Diabetes Limits	Non-Insulin Dependent Diabetes Limits
Urine and blood glucose testing strips	150 per 30 days	100 per 30 days
Lancets	200 per 30 days	100 per 30 days
Insulin Syringe and needle combinations	100 per 30 days	Not allowed
Pen needles	100 per 30 days	Not allowed

List patient's diagnosis and date of onset below.

ICD-9 Codes	Clinical Diagnosis	Date Of Onset

Which of the following are applicable to this patient?

Does Patient:	Yes	No
Have impaired mobility?		
Have visual impairments?		
Have skin break down?		
Have nerve/circulation problems?		
Have renal involvement?		

Date patient last examined by prescriber:

_____/_____/_____

List other complications and/or conditions which may impact the management of the patient's diabetes.

List below all supplies with their quantity/frequency and give prescriber justification for each of them.

Begin Date	Supply Item	Length of Time	Quantity/ Frequency	Clinical Justification

Attach the patient's blood glucose log and any other pertinent medical documentation and fax or mail to the address listed above

Prescriber Certification of Medical Necessity: I certify that this patient meets the program eligibility criteria and that these supplies are part of my course of treatment and they are "Reasonable, Medically Necessary, and are most cost effective", and are not a convenience item for the recipient, family, attending practitioner, other practitioner or supplier. To my knowledge, the above information is accurate.

_____ ____/____/____
Prescriber's Signature Date
(Must be completed, signed and dated by the Practitioner.)