Medicare Diabetic Strip Guidelines

Requirements for the Written order from the doctor

1) Patient Name
2) Specific frequency of testing (**NO MORE PRN OR AS NEEDED ORDERS**)
3) Length of need for test strips
4) Doctor's name and signature
5) Start date of order if different than signed date

Maximum Glucose Testing Supplies Allowances

Patient Type	**Maximum Allowance (EVERY 3 MONTHS)**
Insulin Dependent	300 test strips (testing three times a day) 300 lancets (three times a day)
Non-insulin Dependent	100 test strips (once a day) 100 lancets (once a day)

For Quantity of Test Strips exceeding Maximum Allowance

1) Must have seen treating physician within the prior six months to date of service
2) Must have document of actual testing frequency(i.e. **We must get a copy of the patients testing logs**)

Modifiers to make sure are on the Sales Order

KS: non-insulin users

KX: Insulin users

-these modifiers should automatically show up when you choose insulin or non-insulin dependent

-also make sure the dates are **SPANNED CORRECTLY** (i.e. if the patient is getting 100 strips and is non-insulin then it should be spanned for three months not one month. You will have to change the date at the bottom in the items page)

SPEED SCRIPT DIABETIC FORM
JAYHAWK PHARMACY SERVICES
2860 SW MISSION WOODS DRIVE
TOPEKA, KS 66614
785-228-9700
785-228-1375 FAX

Patient Name:_____DOB:_____DATE:_____
Address:_____
City:_____State:_____Zip:_____
Phone:_____Medicare ID:_____

>Patient Diagnosis: __ Type 1 Controlled (250.01) __Type 1 Uncontrolled (250.03)
__Type 2 Controlled (250.00) __Type 2 Uncontrolled (250.02_
__Other:_____
>Does the patient use insulin: __Yes __No
>Testing Frequency:_____Times/Day

__TrueTrack Meter
__TrueTrack test strips Qty:_____ Refills:_____
__Reliamed Lancets Qty:_____ Refills:_____

>**MEDICARE UTILIZATION GUIDELINES:**
TYPE 1 DIABETIC: ALLOWED #300 TEST STRIPS AND LANCETS PER 100 DAYS
TYPE 2 DIABETIC: ALLOWED #100 TEST STRIPS AND LANCETS PER 100 DAYS

Medicare requires an explanation for testing more frequently than 1x day non-insulin and 3x day insulin treated: therefore, I confirm that I have evaluated this patient within the last six(6) month to assess their diabetes control and have noted below the reason(s) for high testing frequency.

I, the undersigned, certify that the above prescribed supplies/equipment are medically necessary for this patient's well being. In my opinion, the supplies are both reasonable and necessary to the accepted standards of medical practice in treatment of this patient's condition. By signing this form, I am confirming that the above information is accurate.

Physician Name:_____
Address:_____City:_____State:_____Zip:_____
Phone:_____Fax:_____

_____ _____
PHYSICIAN SIGNATURE DATE