Pharmacy Medical Necessity Guidelines
Blood Glucose Test Strips, Ketone Strips and Monitors

Effective: 9/12/14

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<th>Clinical Documentation and Prior Authorization Required</th>
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**OVERVIEW**

Diabetes testing supplies by Abbott are our preferred products.

Blood glucose test strips by Abbott do not require prior authorization as long as the quantity does not exceed the quantity limit (QL) of 150 strips per 30 days.

Blood glucose monitors by Abbott do not require prior authorization as long as the quantity does not exceed two meters per year.

Ketone test strips do not require prior authorization as long as the quantity does not exceed 20 strips per 30 days.

**PHARMACY COVERAGE GUIDELINES**

Tufts Health Plan – Network Health may authorize coverage of non-preferred blood glucose monitors, test strips, and ketone strips for members when all of the following criteria are met and limitations do not apply:

- The request is for a short-term period until the member can obtain and utilize the new meter and test strips OR
- The provider documents the member's inability to switch or effectively utilize the preferred glucose monitors by Abbott OR
- The member is on an insulin pump that requires a specific monitor or test strip

For requests for blood glucose test strips that exceed the QL:

- The member is diagnosed with gestational diabetes or a short-term condition OR
- The member is on an insulin pump OR
- The provider documents poor or fluctuating blood sugar control

For requests for ketone test strips that exceed the QL:

- The request is for a short-term condition, such as acute infection, pancreatitis, or changes in insulin therapy OR
- The provider documents a concern with recurrent diabetic ketoacidosis or hyperosmolar hyperglycemic states (HHS)/hyperglycemic crises; conditions may include, but are not limited to, unstable cardiovascular disease (MI, cerebrovascular accidents), new-onset type 1 DM, eating disorders

**LIMITATIONS**

Approval of non-preferred products will be for the same quantity as in place with the preferred products, i.e. 2 meters per year and up to 5 blood glucose test strips per day.

Quantities approved that exceed the limit for short-term conditions will be approved for up to 1 year.

**CODES**

None
REFERENCES

APPROVAL HISTORY
- 9/8/2014: Reviewed by the Pharmacy and Therapeutics Committee
- 4/12/2012: Reviewed by the Pharmacy and Therapeutics Committee
- 7/16/2009: Reviewed by the Pharmacy and Therapeutics Committee

BACKGROUND, PRODUCT, AND DISCLAIMER INFORMATION
Pharmacy Medical Necessity Guidelines have been developed for determining coverage for Tufts Health Plan – Network Health benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. They are used in conjunction with the applicable Member Handbook and in coordination with the member’s physician(s). Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the Tufts Health Plan – Network Health service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. Tufts Health Plan – Network Health reviews Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

Pharmacy Medical Necessity Guidelines apply to all fully insured Tufts Health Plan – Network Health offerings unless otherwise noted in this policy or the applicable Member Handbook. Check the applicable product formulary in the Pharmacy section of our website to determine if the drug requires you to get prior authorization.

For Tufts Health Unify (Medicare-Medicaid One Care for people ages 21 – 64), please refer to Tufts Health Unify Prior Authorization Medical Necessity Guidelines.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines, when applicable, and adherence to plan policies and procedures and claims editing logic.