TRICARE **Quantity Limit** Override Request Form for Self-Monitoring Blood Glucose System (SMBGS) **Glucose Test Strips**

6093

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

PLEASE NOTE: For Active Duty Service Members, even if coverage will NOT BE APPROVED per this form, it still must be initially submitted to the TPharm Contractor for review. Subsequent reconsideration is allowed at the appropriate Military Treatment Facility.

For initial review by the TPharm Contractor;

- The provider may **call**: **1-866-684-4488**
  or the completed form may be **faxed** to:
  1-866-684-4477

- The patient may attach the completed form
  to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**
  or **email** the form only to:
  TPharmPA@express-scripts.com

Step 1

Please complete patient and physician information (please print):

Patient Name: ______________________________ Physician Name: ______________________________

Address: ______________________________ Address: ______________________________

______________________________ ______________________________

Sponsor ID #: ______________________________ Phone #: ______________________________

Date of Birth: Secure Fax #:

Step 2

Please note: Quantities of 100 test strips per 30 days and 300 test strips per 90 days are covered without prior authorization. If a greater quantity is requested, please complete this QUANTITY LIMIT override form (6093). ***If the standard quantity is sufficient, there is no need to complete this Quantity Limit override form (6093).***

Brand / name of requested test strip: ____

Quantity requested: _________ strips for ________ days supply

Step 3

Please complete the clinical assessment:

Question		
1. **How often is the patient directed to test their blood sugar level (glucose level)?** (for example, how many times per day, testing directions)	______________________________ Proceed to question 2	
2. **Is the patient using a continuous blood glucose monitoring (CGM) system?**	☐ Yes Proceed to question 7	☐ No Proceed to question 3
3. **Is the patient receiving insulin or using an insulin pump?**	☐ Yes **Sign and date below**	☐ No Proceed to question 4
4. **Is the patient a female with a diagnosis of gestational diabetes?**	☐ Yes **Sign and date below**	☐ No Proceed to question 5

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5. Does the patient require more frequent testing due to an endocrine disorder, for example, insulinoma, endogenous hyperinsulinism, non-islet cell tumor, or type 1 diabetes mellitus?	☐ Yes **Sign and date below**	☐ No Proceed to question 6
6. Does the patient have a history of poorly-controlled blood glucose levels with a history of adverse outcomes requiring medical intervention (for example, ketoacidosis or hypoglycemic episode)**?**	☐ Yes **Sign and date below**	☐ No Proceed to question 7
7. What is the reason the patient requires a quantity of test strips greater than the standard quantity of 100 strips per 30 day supply? (for example, what is the reason that the patient needs to test more frequently?)	______________________________ **Sign and date below**	

Step 4 **I certify the above is true to the best of my knowledge.** Please sign and date:

_______________________________ Prescriber Signature

____________ Date

[15 Nov 2023]