Edgerton Pharmacy and boutique

DME Supply **Requirements for Medicare** Patients

In order for Medicare to cover some of the patient's cost for their test strips and lancets, the following must be followed as per Medicare Guidelines:

The Prescription MUST contain the following:

- Specific type of meter, strips, and lancets
- SIG-specific with number of times per day testing (PRN testing is not able to be used when figuring day supply)
- Quantity used per month (this MUST be specified if PRN testing is on the RX)
- Diagnosis (ICD-10)
- Verification that the patient has received training or is scheduled to complete training in the use of the monitor, test strips and lancets

The Prescription may be sent to the pharmacy via:

- Fax (this MUST be hand signed and dated by the provider-a prescription received as a fax is viewed as a paper prescription)
- Written hard copy (this must be hand signed and dated by provider)
- E-Script (At this time, our software program is not Medicare compliant as it does not specifically state "Electronically Signed By" or "Verified by". This is something we are working on getting updated)

Please note: these prescriptions cannot be transferred from another pharmacy. In the event that the patient wishes to switch pharmacies, the new location with require a new prescription from the provider.

Medicare Guidelines for testing frequency:

- Non-Insulin dependent may receive 100 test strips and lancets every 3 months (100 days)
  (Testing once daily)
- Insulin dependent may receive 100 test strips and lancets every month (33 days)
  (Testing three times daily)

If testing **ABOVE** guidelines the following **MUST** be on file at the pharmacy prior to dispensing the prescription:

- A new prescription every 6 months (We are unable to accept E-Rx at this time-see above)
- A provider signed statement of medical necessity of exceeding the guidelines every 6 months (this includes the Patient seeing the Provider every 6 months)
- One month of the patient's blood glucose results reviewed, signed and dated on each page by the provider from within the last six months

Thank you for your attention to this matter!

The information above may not be completed by the pharmacy or anyone in a financial relationship with the pharmacy. All information must be received in completion prior to filling prescription

Medicare Diabetic Supply Prescription Form

Please complete to clarify your patient's diabetic supply prescription and **Fax to Edgerton Pharmacy at 608-884-7725**.

Patient Name: _____ DOB: _____

Brand of Items Being Ordered:

(ex: Contour Next EZ Meter, Contour Next Test Strips, Microlet Lancets, etc)

Meter: _____ Sig: _____

Test Strips: _____ Sig: _____ Qty: (multiple of 50) _____ Refills: _____

Lancets: _____ Sig: _____ Qty: (multiple of 100) _____ Refills: _____

Diagnosis (ICD-10): _____ Patient uses insulin (circle one): Y N

- ☐ Patient has received training or is scheduled to complete training in the use of the monitor, test strips and lancing devices

Provider Name (Printed) _____ Signature _____ Date _____

Statement of Treating Provider Re: Glucose Monitor Test Strips Exceeding Policy Guidelines

The following **MUST** be completed by the treating Provider if the patient:

- Is being treated with insulin AND is testing more than 3 times per day

  OR
- Is NOT being treated with insulin and is testing more than once per day

The following information **must also be provided by the provider every 6 months** to the pharmacy, along with one month of the patient's blood glucose results reviewed, signed and dated by the provider.

Y N 1) Do you treat this patient for Diabetes?

Y N 2) Is the patient currently using insulin injections to control their diabetes?

3) What was the date of the last time you saw the patient for their diabetes? (NOTE-must be every 6 months if exceeding guidelines) _____

4) Give **specific** reasons for quantities of test strips which exceed the policy guidelines listed above. (If the reason is related to the initiation or dosage change of a drug, give name and date.)

_____

_____

Diagnosis (ICD-10): _____

Provider name (Printed) _____ NPI _____

(Signature)_____ Date_____

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