Blood Pressure Monitor Prescription Referral Form

Please complete this form and fax it to a contracted IEHP DME Pharmacy

Member Name:	Prescriber Name:
DOB:	NPI:
Phone:	Office Phone:
IEHP ID:	Office Fax:
Address:	Office Address:

Any Blood Pressure Monitor costing less than $99 is covered.

Medical Justification (Please select one):

☐ **Confirmed diagnosis of Hypertension**

☐ **Suspected White Coat Hypertension (All criteria must be met)**

- Office blood pressure >140/90 mm Hg on at least three separate clinic/office visits with two separate measurements made at each visit
- At least two documented blood pressure measurements taken outside the office which are <140/90 mm Hg
- No evidence of end-organ damage

☐ **Confirmed diagnosis of End Stage Renal Disease**

☐ **Confirmed diagnosis of a Cardiovascular Disease that affects blood pressure**

- Includes chronic heart failure, heart valve problems, previous history of stroke, or stents

☐ **Other: Please provide medical justification**

____

Blood Pressure Monitor

Sig: Use As Directed
Quantity: One (1)

Cuff Size (Please select one):

☐ **Small Adult / Pediatric** (16 – 24 cm **OR** 6.3 – 9.4 in)

☐ **Medium Adult** (24 – 36 cm **OR** 9.4 – 14.2 in)

☐ **Large Adult** (36 – 42 cm **OR** 14.2 – 16.5 in)

☐ **Extra Large Adult** (42 – 60 cm **OR** 16.5 – 23.6 in)

Prescriber Signature: ____________________________

Date: ____