Prior Authorization Request 2810 N. Parham Road Suite 305 Henrico, VA 23219	**ColoradoPAR Program** Medical Review Department	Phone: 1-720-689-6340 Fax: 1-800-922-3508

QUESTIONNAIRE #18
BLOOD PRESSURE UNIT/MONITOR

Member Name		Health First Colorado ID #	

Length of Need		Height	
End Date		Weight	

The information requested below is required to determine medical necessity. Complete this form and attach to the completed Prior Authorization Request (PAR).

1. What is the complete diagnosis with complicating factors?	
2. Indicate the dates and the latest three blood pressure readings of the member:	**Date** / **Reading** / **Date** / **Reading**
3. How frequently does the blood pressure need to be monitored?	
4. What medication(s) is the member on?	
5. If ordering an automatic monitor, explain why a manual monitor will not meet the member's needs:	
6. Supply any additional information that will assist us in determining **medical necessity** for this request:	

Print Prescriber Name _____

Prescriber Signature _____

Date _____

Revised September 2021