INLAND EMPIRE HEALTH PLAN

Blood Pressure Monitor Request Form

In order to expedite the delivery of the Blood Pressure Monitor, please fax this prescription to one of our contracted DME suppliers. WeCare Pharmacy is the IEHP preferred provider.

IEHP covers two different blood pressure monitors:

- WeCare Pharmacy: Foracare Test N'GO Bluetooth Automatic Blood Pressure Monitor

  Features:
  - IEHP Telehealth program compatible
  - Bluetooth connectivity
  - Stores 200 of the most recent readings
  - LCD Backlight
  - Systolic, Diastolic, and pulse
  - Oscilloscope measuring method (automatic inflation)
  - Power Saving: Automatic power off if system is idle for 3 minutes
  - iFORA BP: Download free from Apple Store and Google Play Store
  - Adjustable cuff size

- Other IEHP Contracted Pharmacy: Omron 5 series OR any other BPM machines with cost <$65

  Features of Omron 5 series:
  - **NOT** compatible with IEHP Telehealth program
  - Dual settings for two users
  - 100 readings memory storage with date and time stamp
  - Wide range cuff that fits standard and large arms (9 to 17 inch circumference)
  - Compare patient's blood pressure level with the Blood Pressure Level Indicator
  - Alert patient if the heart rate is irregular during reading
  - Advanced averaging automatically displays the average of up to the last 3 readings taken within the last 10 minutes

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Blood Pressure Monitor Prescription Referral Form

Please provide all Member information below to facilitate this request

Member Name:	**Provider Name:**
DOB:	**NPI:**
Phone:	**Office Phone:**
IEHP ID:	**Office Fax:**
Address:	**Office Address:**

Medical Justification (Please choose one):

- ☐ **Suspected White Coat Hypertension:**
  - 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; **and**
  - No evidence of end-organ damage.
- ☐ **Confirmed diagnosis of End Stage Renal Disease**
- ☐ **Confirmed diagnosis of Hypertension**
- ☐ **Confirmed diagnosis of a Cardiovascular Disease that affects blood pressure**
  - **Chronic heart failure, heart valve problems, previous history of stroke, or stents.**
- ☐ **Other: Please provide medical justification**

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Blood Pressure Monitor

Sig: Use As Directed
Quantity: One (1)

Cuff Size: _____

Signature: _____
Date: _____