ENHANCED PHARMACY BENEFIT

Member name	PEHP Member ID:

Address	Contact Information
	(please check preferred contact below) Daytime phone: ☐ _____ Alternate phone: ☐ _____ Email address: ☐ _____

TO BE COMPLETED BY CLINICIAN

Biometrics

Height	Weight	BMI	Blood pressure		Waist circumference
inches	lbs.		/	Date:	inches

Laboratory Values

A1c		Serum creatinine		Is patient taking an ACEI or ARB?	If NO, why?
%	Date:	mg/dL	Date:	YES NO	

Lipid Profile

Date	Total cholesterol	High density lipoprotein cholesterol HDL-C	Low density lipoprotein cholesterol LDL-C	Triglycerides

Microalbumin Screen

Known nephropathy?	If NO, microalbumin /creatinine ratio (ACR)	
YES NO	mg/mmol	**or** µg albumin / mg creatinine

Exam History		Insulin Use				
Date of most recent dilated retinal exam (DRE)	Date of most recent diabetic foot exam	Average number of blood glucose tests per day	Brand of short-acting insulin used (circle one)	Average number of **short**-acting insulin **UNITS (not injections)** per day	Brand of long-acting insulin used (circle one)	Average number of **long-acting** insulin **UNITS (not injections)** per day
			Novolog Novolin R		Lantus Novolin 70/30 Novolin N	

Physician name:		
Address:		
Phone:	**Fax:**	**Email:**

Physician signature *(form is not valid without Physician's signature)*	**Date**

Please return form to:	PEHP Pharmacy Department **FAX # 801.245.7774** or mail to: PEHP Pharmacy Department 560 E 200 S, Salt Lake City, UT 84102