

Clinical Policy: Quantity and High Dollar Limits- Lancets and Alcohol Swabs

Reference Number: AZ.CP.PMN.1018

Effective Date: 12.1.25

Last Review Date: 12.30.25

Line of Business: Arizona Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

Description

The intent of this policy is to implement quantity limits on products

Indication(s)

Various

Policy/Criteria

Provider must submit documentation (which may include office chart notes and lab results) supporting that member has met all approval criteria

It is the policy of Arizona Complete Health that the following items have quantity limits:

I. Initial Approval Criteria

A. Lancets:

1. An approval on file for blood glucose testing strips of more than 100 per 30 days.
2. And medical necessity documented for requests greater than the current limit of 7 lancets per day.
3. No overrides for high dollar limit of \$26.00.

Approval duration: 1 year

B. Alcohol swabs:

1. An approval on file that requires injections or blood glucose testing more than 100 per 30 days.
2. And medical necessity documented for requests greater than the current limit of 7 alcohol swabs per day.
3. No overrides for high dollar limit of \$15.00.

Approval duration: 1 year

II. Continued Therapy

A. Lancets:

1. Currently receiving lancets via a previous review and authorization.

Approval duration: 1 year

B. Alcohol swabs:

1. Currently receiving alcohol swabs via a previous review and authorization.

Approval duration: 1 year

III. Appendices/General Information

None

IV. References

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New criteria created for items that require Quantity Limits	11.25	12.25

Important Reminder

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

CLINICAL POLICY

Quantity Limits



This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

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Note: For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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