



Please complete ALL information below and fax your request to 1-888-671-5285

Continuous Glucose Monitoring Prior Authorization Request Form

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
<input type="checkbox"/> Check if generic substitution is acceptable	Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy		

Clinical Information (required)	
Select the diagnosis below:	
<input type="checkbox"/> Type 1 diabetes mellitus	
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____	

<p>Clinical information:</p> <p>Is the patient pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is the requested device prescribed by or in consultation with an endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there documentation the patient requires greater than or equal to 2 insulin injections per day? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there documentation the patient utilizes an insulin pump? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient have a documented history of poorly controlled diabetes (i.e., severe ketosis or hypoglycemic episodes without experiencing warning and recognition of symptoms or hypoglycemic unawareness)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does the patient demonstrate an understanding of the fundamentals of diabetes self-management including regular testing of blood glucose levels greater than or equal to 3 times per day? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is there documentation of accurate blood glucose testing records? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Has the patient received diabetes self-management education and instruction on utilizing Continuous Glucose Monitoring Systems (CGMs) including basic care of the CGMs (e.g., insertion, calibration, expectations), use of real-time CGM application in diabetic care, and alarm use and problem solving? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.