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:
❑ Check if **generic substitution** is acceptable	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Type 1 diabetes mellitus

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical information:

Is the patient pregnant? ❑ **Yes** ❑ **No**

Is the requested device prescribed by or in consultation with an endocrinologist? ❑ **Yes** ❑ **No**

Is there documentation the patient requires greater than or equal to 2 insulin injections per day? ❑ **Yes** ❑ **No**

Is there documentation the patient utilizes an insulin pump? ❑ **Yes** ❑ **No**

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)? ❑ **Yes** ❑ **No**

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? ❑ **Yes** ❑ **No**

Is there documentation of accurate blood glucose testing records? ❑ **Yes** ❑ **No**

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? ❑ **Yes** ❑ **No**

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.