carolina complete health

Pharmacy Prior Approval Request for Continuous Glucose Monitors

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext._____

Drug Information

8. Transmitter/ Sensor Name: ☐ Dexcom G6 ☐ FreeStyle Libre 2 ☐ FreeStyle Libre 14 day
9 Quantity for Transmitter (G6) _____ (Max 1) 10. Quantity for Dexcom (G6) Sensor _____ (Max 3)
11. Quantity for Reader(Libre 14 day/Libre 2) _____ (Max 1) 12. Quantity for Sensors (Libre 14 day / Libre 2) _____ (Max 2)
13. Length of therapy (in days) for Dexcom G6 Transmitter, G6 Sensor, Libre 14 day /Libre 2 Reader and Sensors:
☐ up to 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days ☐ Other: _____
Max Length of Therapy for Initial Authorization is 180 days
For Dexcom G6 only:
14. Does the beneficiary have a smart device (phone/computer/tablet) to receive transmissions from the Dexcom G6?
☐ **Yes** ☐ **No** (Answering "NO" indicates that the beneficiary needs the Dexcom Receiver)

Clinical Information

For initial therapy, please answer questions 1-10, (max 6 months authorization):
1. Does the beneficiary have a diagnosis of insulin-dependent diabetes? ☐ **Yes** ☐ **No**
2. Does the beneficiary require two (2) or more insulin injections daily? ☐ **Yes** ☐ **No**
3. Does the beneficiary's insulin treatment regimen require frequent adjustment based on standard BGM or non-therapeutic CGM testing? ☐ **Yes** ☐ **No**
4. Is the beneficiary and/or caregiver(s) willing and able to use the therapeutic CGM system as prescribed? ☐ **Yes** ☐ **No**
5. Has the beneficiary had a face-to-face encounter with the treating practitioner to evaluate the beneficiary's glycemic control and determine that criteria one through five (1-5) above have been met, within six months of the initial authorization? ☐ **Yes** ☐ **No**
6. Does the beneficiary use an external insulin pump? ☐ **Yes** ☐ **No**
7. For coverage of Dexcom G6; is the beneficiary age 2 years or older? ☐ **Yes** ☐ **No**
8. For coverage of FreeStyle Libre 14 day is the beneficiary age 18 years or older? ☐ **Yes** ☐ **No**
9. For coverage of FreeStyle Libre 2 is the beneficiary age 4 years or older? ☐ **Yes** ☐ **No**
10. For coverage of FreeStyle Libre 14 day, has the beneficiary tried using Dexcom G6, or Freestyle Libre 2? ☐ **Yes** ☐ **No**
If no, is there a clinical reason Dexcom G6, or Freestyle Libre 2 could not be used? ☐ **Yes** ☐ **No**
If yes, explain _____

For first reauthorization, please answer questions 11-13, (max 12-month authorization) DOCUMENTATION REQUIRED:
11. Has the beneficiary been using the CGM as prescribed? ☐ **Yes** ☐ **No**
12. Has the beneficiary been able to improve glycemic control? ☐ **Yes** ☐ **No**
13. Does the beneficiary continue to use as external insulin pump? ☐ **Yes** ☐ **No**

For Subsequent reauthorizations please answer questions 14-17, (max 12-month authorization) DOCUMENTATION REQUIRED
14. Has the beneficiary had a face-to-face encounter with the ordering practitioner to evaluate the efficacy of the CGM system no more than three (3) months prior to submission of this reauthorization request? ☐ **Yes** ☐ **No**
15. Has the beneficiary been using the CGM system as prescribed? ☐ **Yes** ☐ **No**
16. Has the beneficiary been able to maintain or further improve glycemic control? ☐ **Yes** ☐ **No**
17. Does the beneficiary continue to use an external insulin pump? ☐ **Yes** ☐ **No**

Signature of Prescriber:_____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to (833) 404-2393 Pharmacy PA Call Center: (833) 585-4309

https://www.covermymeds.com/main/prior-authorization-forms/