AmeriHealth Caritas North Carolina

# Pharmacy Request for Prior Approval – 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. Prescriber Name: _____ NPI #: _____
Mailing address: _____ City: _____ State: _____ ZIP: _____
7. Requester Contact Information: _____
Name: _____ Phone #: _____ Fax #: _____

**Monitor Information**

8. Transmitter/Sensor Name: ☐ Dexcom G6 ☐ Dexcom G7 ☐ FreeStyle Libre 14 day ☐ FreeStyle Libre 2 / FreeStyle Libre 3
9. Quantity for Transmitter (G6) _____ (Max 1) 10. Quantity for Dexcom (G6/G7) Sensor _____ (Max 3)
11. Quantity for Reader (Libre 14 day / Libre 2 and 3) _____ (Max 1) 12. Quantity for Sensors (Libre 14 day / Libre 2 and Libre 3) _____ (Max 2)
13. Length of therapy (in days) for Dexcom G6 Transmitter, G6 Sensor, Libre 14 day / Libre 2 and 3 Readers 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 and G7 only:**

14. Does the beneficiary have a smart device (phone/computer/tablet) to receive transmissions from the Dexcom G6 or G7?
Yes___ No___ (Answering "NO" indicates beneficiary needs the Dexcom Receiver)

**Clinical Information**

**For initial therapy, please answer questions 1-9 (max 6 months authorization)**

1. Does the beneficiary have a diagnosis of insulin-dependent diabetes? Yes___ No___
2. Is the beneficiary and/or caregiver(s) willing and able to use the therapeutic CGM system as prescribed? Yes___ No___
3. 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 and two (1 and 2) above have been met, within six months of the initial authorization? Yes___ No___
4. Does the beneficiary use an external insulin pump? Yes___ No___
5. Does the beneficiary have a diagnosis of gestational diabetes? Yes___ No___
6. For coverage of Dexcom G6 or G7: is the beneficiary age 2 years or older? Yes___ No___
7. For coverage of FreeStyle Libre 14 day: is the beneficiary age 18 years or older? Yes___ No___
8. For coverage of FreeStyle Libre 2 or 3: is the beneficiary age 4 years or older? Yes___ No___
9. For coverage of FreeStyle Libre 14 day: has the beneficiary tried using Dexcom G6 or G7, or Freestyle Libre 2 or 3? Yes___ No___
   If no, is there a clinical reason Dexcom G6, Dexcom G7 or Freestyle Libre 2 or 3 could not be used? Yes___ No___
   If yes, explain: _____

**For first reauthorization, please answer questions 10-12: (max 12-month authorization) DOCUMENTATION REQUIRED**

10. Has the beneficiary been using the CGM as prescribed? Yes___ No___
11. Has the beneficiary been able to improve glycemic control? Yes___ No___
12. Does the beneficiary continue to use an external insulin pump? Yes___ No___

**For subsequent reauthorizations, please answer questions 13-16: (max 12-month authorization) DOCUMENTATION REQUIRED**

13. 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___
14. Has the beneficiary been using the CGM system as prescribed? Yes___ No___
15. Has the beneficiary been able to maintain or further improve glycemic control? Yes___ No___
16. 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: 1-877-234-4274, or call Pharmacy Prior Authorization: 1-866-885-1406**