UTAH MEDICAID PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Continuous Glucose Monitor (CGM)

Member and Medication Information **BOLD** indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information **BOLD** indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

Dexcom G6 and G7 *Preferred Product	Freestyle Libre 2 and Libre 3	Freestyle Libre 14 days	Guardian Connect
2 years of age and older	4 years of age and older	18 years of age and older	14 to 75 years of age

Criteria for Approval: (***All*** of the following criteria must be met)

- ☐ The patient has a diagnosis of diabetes mellitus ☐ Type 1 ☐ Type 2 ☐ Gestational ☐ Other: _____
- ☐ The patient and/or caregiver adheres to a comprehensive diabetes treatment plan supervised by the treating provider and can recognize and respond to the messages, alarms and alerts of the device
- ☐ The provider attests that the patient and/or caregiver has received (or will receive) appropriate ongoing counseling and training for CGM use

Additional Criteria for Type 2 Diabetes, Gestational Diabetes or Other Diabetes:

*(**All** the following criteria must be met)*

- ☐ The patient has been adherent to blood glucose testing
- ☐ One of the following applies:
  - ☐ The patient's insulin regimen requires frequent adjustment based on blood glucose monitoring (BGM) or CGM testing results
  - ☐ The patient has hypoglycemia unawareness (onset of neuroglycopenia before the appearance of autonomic warning symptoms or failure to sense a significant fall in blood glucose below normal levels)
  - ☐ The patient experiences recurrent episodes of level 2 hypoglycemia (glucose level of less than 54mg/dl), which are not attributable to a dosing error
  - ☐ A history of one level 3 hypoglycemic event (glucose level less than 54mg/dl) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia

One of the following criteria must be met:

- ☐ Patient requires insulin **OR**

- ☐ Patient is not insulin dependent and has a history of problematic hypoglycemia
- ☐ Other clinical rationale for CGM: _____

Additional Criteria for Non-Diabetes Endocrine Disorders Causing Glycemic Variability, Off-Label Use:

- ☐ Requests for any off-label indications must be supported by at least one (1) major multi-site study or three (3) smaller studies published in JAMA, NEJM, Lancet or other peer review specialty medical journals within the most recent five (5) years. Supporting documentation must be included. Compendia use must be recommended by generally accepted compendia such as American Hospital Formulary Service Drug Information (AHFS), United States Pharmacopeia-Drug Information (USP-DI), and the DRUGDEX Information System.

Replacement Receiver *(May be authorized when documentation confirms all the following):*

- ☐ The current device is deemed inoperable or ineffective due to damage from events outside of the patient's control
- ☐ The patient is compliant with the device, device is required and continues to provide benefit to the patient's diabetic regimen
- ☐ A replacement cannot be obtained through the supplier or manufacturer (warranty has expired)

Non-preferred product: *(Above criteria must also be met)*

- ☐ Trial and failure of preferred Dexcom G6 or G7, or prescriber must demonstrate medical necessity for non-preferred product.
- ☐ Details: _____ Chart note page #: _____

Reauthorization Criteria *(All the following criteria must be met)*

- ☐ Updated documentation from the treating provider indicating the device is required and continues to provide benefit to the patient's diabetic regimen
- ☐ Documentation of a face-to-face visit with the provider in the last 6 months

Initial Authorization: Up to six (6) months
Reauthorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date