HEALTHY U CHIP

PRIOR AUTHORIZATION REQUEST FORM

Continuous Glucose Monitor (CGM)- Retail Pharmacy Only

For authorization, please answer each question and fax this form PLUS chart notes back to the Healthy U CHIP Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: 385-425-5094

Disclaimer: Prior Authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:

Height/Weight:

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Preferred: ☐ Dexcom 7 ☐ Dexcom G6 ☐ Freestyle Libre 1 ☐ Freestyle Libre 2 ☐ Freestyle Libre 3
Non-formulary: ☐ Dexcom G4 ☐ Dexcom G5 ☐ Eversense Implantable CGMs ☐ Medtronic Enlite ☐ Medtronic Guardian

Dosing/Frequency:_____

If the request is for reauthorization, proceed to reauthorization section

Questions	Yes	No	Comments/Notes
GESTATIONAL DIABETES			
1. Does the member have gestational diabetes or diabetes during pregnancy?	☐	☐	**Please provide documentation**
DIABETES MELLITUS			
1. Is the member 2 years of age or older?	☐	☐	
2. Is the prescribing provider an endocrinologist or diabetes specialist?	☐	☐	**Please provide documentation**
3. For Type 1 Diabetes, if the member is ≥ 13 years of age, has the member had at least one year of subcutaneous insulin therapy?	☐	☐	**Please provide documentation**
4. Does the member adhere to a comprehensive diabetes treatment plan and is the member capable of recognizing and responding to the alarms and alerts of the device?	☐	☐	
5. Will the member receive appropriate ongoing counseling and training for CGM use?	☐	☐	
6. Does documentation show diabetes specialist's assessment of ability to train member on appropriate use of continuous glucose monitor?	☐	☐	**Please provide documentation**
7. Does documentation show at least two visits with a diabetes specialist during the six months prior to initiation?	☐	☐	**Please provide documentation**

8. Does documentation show that the member is taking medications that are causing impaired cognitive function or that are affecting the members' ability to appropriately respond to CGM alerts?	☐	☐	**Please provide documentation**
9. Does the member meet one or more of the following criteria while on multiple daily injection insulin or insulin pump therapy? • Glycosylated hemoglobin levels (HbA1c) greater than 8%. • Recent history (within the last six months) of significant, recurring hypoglycemia (less than 60mg/dL or requiring assistance). • Wide fluctuations (well above and below set glycemic targets) in blood glucose before and after meal times, despite appropriate adjustment of doses. • At least one documented incidence of hyperglycemic hyperosmotic syndrome or diabetic ketoacidosis within the previous six months.	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Does documentation support active and routine use of device?	☐	☐	**Please provide documentation**
3. Does documentation support use of device has resulted in improved diabetic management?	☐	☐	**Please provide documentation**
4. Has the member had at least two visits with a diabetes specialist within the previous 12 months?	☐	☐	**Please provide documentation**
5. Have Hemoglobin A1c levels been checked at least every 6 months within the previous year?	☐	☐	**Please provide documentation**
6. Does documentation show that the member is adhering to the treatment plan outlined by a diabetes specialist?	☐	☐	**Please provide documentation**

What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.

Additional information:

Physician Signature:

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Policy: PHARM-CHIP-108
Origination Date: 07/01/2024
Reviewed/Revised Date:
Next Review Date:
Current Effective Date: 07/01/2024