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 G7, ☐ 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
1. Does the member have type 1 diabetes mellitus?	☐	☐	**Please provide documentation**
2. Does the member have gestational diabetes or diabetes during pregnancy?	☐	☐	**Please provide documentation**
3. Does the member use an insulin pump?	☐	☐	**Please provide documentation**
4. Does the member have type 2 diabetes mellitus?	☐	☐	**Please provide documentation**
5. Does the member require multiple daily injections of insulin?	☐	☐	**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 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:

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

Policy: PHARM-CHIP-108
Origination Date: 07/01/2024
Reviewed/Revised Date: 11/13/2024
Next Review Date: 11/13/2025
Current Effective Date: 12/01/2024