

PRIOR AUTHORIZATION REQUEST FORM CONTINUOUS GLUCOSE MONITORS

Dexcom Receiver, Dexcom Sensor, Dexcom G7 15 day Sensor, Dexcom G6 Transmitter, FreeStyle Libre Reader, FreeStyle Libre Sensor, Guardian Transmitter, Guardian Sensor

For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid 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 Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

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:

Preferred Products: Dexcom Receiver, Dexcom Sensor, Dexcom G7 15 day Sensor, Dexcom G6 Transmitter, FreeStyle Libre Reader, FreeStyle Libre Sensor

Non-preferred Products: Guardian Transmitter, Guardian Sensor

Product Requested: _____

Directions for Use: _____

Criteria for Approval: (All of the following criteria must be met)	Yes	No
1. Does the patient have a diagnosis of diabetes mellitus? <input type="checkbox"/> Type 1 <input type="checkbox"/> Type 2 <input type="checkbox"/> Gestational <input type="checkbox"/> Other: _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the patient and/or caregiver adhere to a comprehensive diabetes treatment plan supervised by the treating provider and can they recognize and respond to the messages, alarms and alerts of the device?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the provider attest that the patient and/or caregiver has received (or will receive) appropriate ongoing counseling and training for CGM use?	<input type="checkbox"/>	<input type="checkbox"/>
Type 2 Diabetes, Gestational Diabetes or Other Diabetes Additional Criteria: (All of the following criteria must be met)		
4. Has the patient been adherent to blood glucose testing?	<input type="checkbox"/>	<input type="checkbox"/>
5. Does one of the following criteria apply: <input type="checkbox"/> The patient's insulin regimen requires frequent adjustment based on blood glucose monitoring (BGM) or CGM testing results <input type="checkbox"/> 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) <input type="checkbox"/> The patient experiences recurrent episodes of level 2 hypoglycemia (glucose level of less than 54mg/dl), which are not attributable to a dosing error and provider has submitted documentation of medication adjustment and modification to the treatment plan prior to the most recent level 2 event	<input type="checkbox"/>	<input type="checkbox"/>

<input type="checkbox"/> A history of one level 3 hypoglycemia event (glucose level less than 54mg/dl) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia and the patient requires medication with risk of hypoglycemia <input type="checkbox"/> Other clinical rationale for CGM: _____		
Non-Diabetes Endocrine Disorders Causing Glycemia Variability, Off-Label Use Additional Criteria		
6. Has the provider submitted supporting documentation required for any off-label indications, which includes 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	<input type="checkbox"/>	<input type="checkbox"/>
Replacement Receiver: (May be authorized when documentation confirms all of the following)		
7. Is the current device deemed inoperable or ineffective due to damage from events outside of the patient's control?	<input type="checkbox"/>	<input type="checkbox"/>
8. Does the provider attest that the patient is compliant with the device, the device is required and continues to provide benefits to the patient's diabetic regimen?	<input type="checkbox"/>	<input type="checkbox"/>
9. Does the provider attest that a replacement device cannot be obtained through the supplier or manufacturer (warranty has expired)?	<input type="checkbox"/>	<input type="checkbox"/>
Reauthorization		
1. Does the patient still meet initial authorization criteria (on insulin, risk of hypoglycemia, etc.) OR has the provider submitted an updated letter of medical necessity and updated chart notes indicating the device is required and continues to provide benefit to the patient's diabetic regimen?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the provider attest that there has been a documented face-to-face visit with the patient in the last 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
PRESCRIBER CERTIFICATION		
I hereby certify this treatment is indicated, necessary and meets the guidelines for use.		
Physician's Signature:	Date:	

Initial Authorization: Up to one (1) year

Reauthorization: Up to one (1) year

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Policy: PHARM-HYB-108

Origination Date: 01/01/2026

Reviewed/Revised Date: 02/24/2026

Next Review Date: 02/24/2027

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