



# REQUEST FOR PRIOR AUTHORIZATION CONTINUOUS GLUCOSE MONITORS

Prescribing Physician:	
Name (First, Last)	
Direct Phone #	
Fax #	
Physician specialty	

Patient:	
Name (First, Last)	
ID #	
Phone #	Client
Birth Date _ / _ / _	Sex <input type="checkbox"/> M <input type="checkbox"/> F

Name and title of person completing form (please print)
Monitor Brand:
Is this request for a replacement of a <input type="checkbox"/> Monitor <input type="checkbox"/> Sensor <input type="checkbox"/> Transmitter
Will the patient be using the continuous monitoring system <input type="checkbox"/> long-term <input type="checkbox"/> short-term? If short-term, for how long?
Patient's diagnosis:
1. Previous history of a medical condition, allergies or other pertinent medical information that necessitates the use of the continuous glucose monitor:
2. How often is the patient injecting insulin per day?
3. How often does the patient currently monitor blood glucose?
4. Please provide documentation that the patient been counselled of the CGM use.
5. Please provide documentation that the patient is adherent to a diabetic treatment plan and receiving ongoing education and support.

Physician's Signature \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**Office Visit Chart Notes must be submitted for the request to be reviewed**

For ScriptGuideRX use only)

**Fax Request to: SGRX @ 313-264-0985**

Date faxed: ___/___/___
Date received: ___/___/___
Date completed: // ___

Decision (all authorizations are pending valid eligibility)
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