



# PRIOR AUTHORIZATION REQUEST CONTINUOUS GLUCOSE MONITORS

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

| Patient:                      |  |
|-------------------------------|--|
| Name (First, Last)            |  |
| ID #                          | Sex (at birth):<br><input type="checkbox"/> M <input type="checkbox"/> F |
| Phone #                       | Client   |
| Birth Date:<br>____/____/____ | Age  |

Name and title of person completing form (please print): \_\_\_\_\_

| <b>1. Please select the CGM Type:</b><br><input type="checkbox"/> Freestyle Libre <input type="checkbox"/> Freestyle Libre 2 <input type="checkbox"/> Freestyle Libre 3<br><input type="checkbox"/> Dexcom G6/G7 <input type="checkbox"/> Guardian<br><input type="checkbox"/> Other: _____ | <b>2. Product type:</b><br><input type="checkbox"/> Sensor<br><input type="checkbox"/> Transmitter/reader<br><input type="checkbox"/> Both | <b>3. Duration of therapy:</b><br><br> |           |
|---|--|--|-----------|
| <b>4. What is the diagnosis:</b> <input type="checkbox"/> Type 1 Diabetes <input type="checkbox"/> Type 2 Diabetes<br><input type="checkbox"/> Gestational diabetes <input type="checkbox"/> Other _____  |  |  |           |
| <b>5. Has patient been on this CGM before?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes, for how long: _____  |  |  |           |
| <b>6. If this is a request for the transmitter/reader, is the device defective AND out of warranty?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> N/A   |  |  |           |
| <b>7. Please list the type of insulin the patient is currently using below:</b>   |  |  |           |
| Insulin name  | Dosage   | Route (SQ or Insulin Pump)             | Frequency |
|   |  |  |           |
|   |  |  |           |
|   |  |  |           |
| <b>8. Is the patient monitoring blood glucose at least 3 times per day?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No  |  |  |           |
| <b>9. Is the patient on an insulin pump?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No      If yes please specify brand: _____   |  |  |           |
| I (provider name) _____ attest the following:<br><br><b>My patient has been counselled on CGM use and is adherent to a diabetic treatment plan and receives ongoing education and support.</b>  |  |  |           |

Physician's Name (print): \_\_\_\_\_ Title: \_\_\_\_\_

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

Fax PA request form AND Supporting Documentation to: SGRX @ 313-264-0985