PRIOR AUTHORIZATION REQUEST
CONTINUOUS GLUCOSE MONITORS

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

Patient:	
Name (First, Last)	
ID #	Sex (at birth): ❑ M ❑ F
Phone #	Client
Birth Date: ___/___/___	Age

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

1. Please select the CGM Type:	2. Product type:	3. Duration of therapy:
❑ Freestyle Libre ❑ Freestyle Libre 2 ❑ Freestyle Libre 3 ❑ Dexcom G6/G7 ❑ Guardian ❑ Other:_____	❑ Sensor ❑ Transmitter/reader ❑ Both	

4. What is the diagnosis: ❑ Type 1 Diabetes ❑ Type 2 Diabetes
❑ Gestation diabetes ❑ Other _____

5. Has patient been on this CGM before? ❑Yes ❑No If yes, for how long: _____

6. If this is a request for the transmitter/reader, is the device defective AND out of warranty? ❑Yes ❑No ❑N/A

7. Please list the type of insulin the patient is currently using below:

Insulin name	Dosage/Route	Frequency

8. Is the patient monitoring blood glucose at least 3 times per day? ❑Yes ❑No

I (provider name)_____ attest the following:

My patient has been counselled on CGM use and is adherent to a diabetic treatment plan and receives ongoing education and support.

Physician's Name (print): _____ Title: _____

Physician's Signature: _____Date: ___/___/_____

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