REQUEST FOR PRIOR AUTHORIZATION CONTINUOUS GLUCOSE MONITORS

Prescribing Physician:	**Patient:**	
Name (First, Last)	Name (First, Last)	
Direct Phone #	ID #	
Fax #	Phone #	Client
Physician specialty	Birth Date ___/___/_____	Sex ☐M ☐F

Name and title of person completing form (please print)
Monitor Brand:
Is this request for a replacement of a ☐ Monitor ☐ Sensor ☐ Transmitter
Will the patient be using the continuous monitoring system ☐ long-term ☐ 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 are required for the review

For ScriptGuideRX use only)

Date faxed: ____/_____/

Date received: ____/_____/

Date completed: / /_____

Fax Request to: SGRX @ 313-264-0985

Decision (all authorizations are pending valid eligibility)