PRIOR AUTHORIZATION REQUEST
CONTINUOUS GLUCOSE MONITORS

Prescribing Physician	
Name (First, Last)	
Physician Specialty	
Phone #	Fax #

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:
- ☐ Freestyle Libre
- ☐ Freestyle Libre 2
- ☐ Freestyle Libre 3
- ☐ Dexcom G6/G7
- ☐ Guardian
- ☐ Other: _____

2. Product type:
- ☐ Sensor
- ☐ Transmitter/reader
- ☐ Both

3. Duration of therapy:

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

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