Prior Authorization Request Form for Continuous Glucose Monitor

FAX this completed form to (844) 205-3386
OR Mail requests to: Pharmacy Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720
OR Prior authorization may be completed at https://www.covermymeds.com/main/prior-authorization-forms/

I. PROVIDER INFORMATION	II. MEMBER INFORMATION
Prescriber Name:	Member Name:
Prescriber Specialty:	Identification #:
NPI:	Group #:
Office Contact Name:	Date of Birth:
Fax #:	Medication Allergies:
Phone #:	

III. DRUG INFORMATION (One drug request per form)		
Drug name and strength:	Dosage Interval (sig):	Qty. per Day:

IV. REQUIRED DOCUMENTION *(Detailed medical record documentation demonstrating evidence for each item must be submitted with prior authorization request)*

Specify diagnosis & diagnosis code relevant to this request: Dx/Dx Code: _____

Requests for all non-preferred medications: Does the member have a history of trial and failure of or contraindication or intolerance to the preferred Blood Glucose Monitor? *Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred medications in this class.*	☐ Yes ☐ No	*Submit documentation of previous trials/failures, contraindications, and/or intolerances or current use.*

☐ Request does not exceed 1 replacement device per 12 months or 1 device per recommended replacement period outlined by product label

SUBMIT MEDICAL RECORD INFORMATION FOR EACH APPLICABLE ITEM.

DIABETES MELITIS:

- ☐ Diagnosis of diabetes mellitus
- ☐ Prescriber has seen the member within the last 6 months (Last appointment date:_____)
- ☐ Member currently requires blood glucose testing at least 4 times per day
- ☐ Frequent adjustments (≥ 1 adjustment every 3 months) to the member's pharmacological treatment regimen are necessary based on glucose testing results
- ☐ Member requires one of the following:
  - ☐ Requires insulin injections ≥ 3 times per day
  - ☐ Uses a continuous insulin infusion pump
- ☐ Physician visits are planned every 6 months to assess adherence to both continuous glucose monitoring (CGM) regimen and diabetes treatment plan (Next appointment date:_____)

RENEWAL REQUESTS:

- ☐ Documentation supports both of the following:
  - ☐ Replacement device is necessary due to loss, theft or damage
  - ☐ Member is using the product properly and continues to benefit from it evidenced by:_____

IV. ADDITIONAL RATIONALE FOR REQUEST / PERTINENT CLINICAL INFORMATION :

Appropriate clinical information to support the request on the basis of medical necessity must be submitted.	Provider Signature:	Date:

Pharmacy Department will respond via fax or phone within 24 hours.
Requests for prior authorization (PA) requests must include member name, ID#, and drug name. Please include lab reports with requests when appropriate (e.g., Culture and Sensitivity; Hemoglobin A1C; Serum Creatinine; CD4; Hematocrit; WBC, etc.)