# Prior Authorization Request Form for Continuous Glucose Monitor

envolve Pharmacy Solutions | pa health & wellness

**FAX this completed form to (877) 386-4695**

**OR Mail requests to: Envolve Pharmacy Solutions PA Department | 5 River Park Place East, Suite 210 | Fresno, CA 93720**

| I. PROVIDER INFORMATION | II. MEMBER INFORMATION |
|---|---|
| Prescriber Name: | Member Name: |
| Prescriber Specialty: | Identification #: |
| Office Contact Name: | Group #: |
| Group 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<br>☐ 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: |

Envolve Pharmacy Solutions 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.)