Prior Authorization Review Panel

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CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 11/01/2020**
Policy Number: PA.CP.PMN.214	**Effective Date: 01/2020** **Revision Date: 10/2020**
Policy Name: Continuous Glucose Monitors	

Type of Submission – Check all that apply:

- ☐ **New Policy**
- ☐ **Revised Policy***
- ✓ **Annual Review - No Revisions**
- ☐ **Statewide PDL -** *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Q4 2020 annual review: revised criterion requiring frequent adjustments to member's pharmacologic treatment regimen to apply to type 2 diabetes only; References reviewed and updated.

Name of Authorized Individual (Please type or print): **Auren Weinberg, MD**	**Signature of Authorized Individual:** 

Clinical Policy: Continuous Glucose Monitors

Reference Number: PA.CP.PMN.214
Effective Date: 01/2020
Last Review Date: 11/2020

Revision Log

Description
Continuous glucose monitors measure interstitial glucose, which correlates well with plasma glucose.

FDA Approved Indication(s)
Continuous glucose monitors are indicated for use in patients with diabetes mellitus to monitor blood glucose levels.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with PA Health & Wellness® that continuous glucose monitors are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Diabetes Mellitus (must meet all)**:**

Replacement of functional features of an existing monitor for an upgrade is not considered medically necessary

1. Diagnosis of diabetes mellitus;
2. Prescriber has seen the member in person within the last 6 months;
3. Member currently requires blood glucose testing ≥ 4 times per day;
4. For type 2 diabetes, frequent adjustments (i.e. ≥ 1 adjustment every 3 months) to the member's pharmacologic treatment regimen are necessary based on glucose testing results;
5. Member meets one of the following (a or b):
   a. Requires insulin injections ≥ 3 times per day;
   b. Uses a continuous insulin infusion pump;
6. In-person physician visits are planned every 6 months to assess adherence to both continuous glucose monitoring (CGM) regimen and diabetes treatment plan;
7. Request does not exceed quantity limit of 1 replacement device per 12 months or 1 device per recommended replacement period as outlined by product labeling, whichever is shorter.

Approval duration: 12 months

B. Other diagnoses/indications: Not applicable

II. Continued Therapy

A. Diabetes Mellitus (must meet all)**:**

Replacement of functional features of an existing monitor for an upgrade is not considered medically necessary

1. Currently receiving product via PA Health & Wellness benefit and documentation supports positive response to using the product or the Continuity of Care policy (PA.LTSS.PHAR.01) applies;
2. Documentation supports both of the following (a and b):
   a. A replacement device is necessary due to loss, theft, or damage;
   b. Member is using the product properly and continues to benefit from it;
3. Request does not exceed quantity limit of 1 replacement device per 12 months or 1 device per recommended replacement period as outlined by product labeling, whichever is shorter.

Approval duration: 12 months

B. Other diagnoses/indications: Not applicable

III. Diagnoses/Indications for which coverage is NOT authorized:

A. Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – PA.CP.PMN.53

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CGM: continuous glucose monitoring
FDA: Food and Drug Administration
SMBG: self-monitoring of blood glucose

Appendix B: Therapeutic Alternatives
Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information

- Blood glucose monitoring (either with self-monitoring [SMBG] or CGM) is a tool used to evaluate whether glycemic targets are being achieved. It enables evaluation of response to both pharmacologic therapy and lifestyle modifications and can therefore help guide treatment decisions and/or self-management.
- The American Diabetes Association, American Association of Clinical Endocrinologists, and American College of Endocrinology do not prefer any one blood glucose monitor brand over another.

V. Dosage and Administration

Usage regimen is individualized based on patient goals.

VI. Product Availability

Monitor and test strip packaging vary by product and manufacturer.

VII. References

1. InterQual 2019 Durable Medical Equipment Criteria, Continuous Glucose Monitors-Senior.
2. American Diabetes Association. Standards of medical care in diabetes—2020. Diabetes Care. 2020; 43(suppl 1): S1-S212. Updated June 5, 2020. Accessed July 1, 2020.
3. Garber AJ, Handelsman Y, Grunberger G, et al. Consensus statement by the American Association of Clinical Endocrinologists and American College of Endocrinology on the comprehensive type 2 diabetes management algorithm – 2020 executive summary. Endocr Pract. 2020; 26(1): 107-139.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Policy created	01/2020	
4Q 2020 annual review: revised criterion requiring frequent adjustments to member's pharmacologic treatment regimen to apply to type 2 diabetes only; references reviewed and updated.	07/2020	11/20