



Prior Authorization Request Form for Continuous Glucose Monitoring

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/>

<input type="checkbox"/> New request <input type="checkbox"/> Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Member name:		City/state/zip:	
Member ID#:	DOB:	Phone:	Fax:

Product(s) requested:			
<input type="checkbox"/> Receiver/reader: _____	Quantity: _____		
<input type="checkbox"/> Transmitters: _____	Quantity: _____ per _____ days	Refills: _____	
<input type="checkbox"/> Sensors: _____	Quantity: _____ per _____ days	Refills: _____	
<input type="checkbox"/> Other: _____	Quantity: _____ per _____ days	Refills: _____	
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	

**Complete all sections that apply to the member and this request.
Check all that apply and submit documentation for each item.**

<p>1. For ALL requests for a Continuous Glucose Monitoring (CGM) Product:</p> <p><input type="checkbox"/> The member has a diagnosis of diabetes</p> <p><input type="checkbox"/> The member has a diagnosis other than diabetes for which CGM is medically necessary – <i>submit documentation supporting the medical necessity of CGM for this member</i></p>
<p>2. For requests for a NON-PREFERRED CGM Product:</p> <p><input type="checkbox"/> The member is using an insulin pump that is compatible with the requested non-preferred CGM Product</p> <p><input type="checkbox"/> The member has a history of trial and failure of the preferred CGM Products (<i>Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.</i>)</p>

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO (844) 205-3386

Prescriber Signature:	Date:
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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.)