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/

☐New request ☐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:

☐Receiver/reader: _____ Quantity: _____

☐Transmitters: _____ Quantity: _____ per _____ days Refills: _____

☐Sensors: _____ Quantity: _____ per _____ days Refills: _____

☐Other: _____ Quantity: _____ per _____ days Refills: _____

Diagnosis *(submit documentation)*:	Dx code (*required*):

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

1. **For ALL requests for a Continuous Glucose Monitoring (CGM) Product:**
   - ☐The member has a diagnosis of diabetes
   - ☐The member has a diagnosis other than diabetes for which CGM is medically necessary – *submit documentation supporting the medical necessity of CGM for this member*

2. **For requests for a NON-PREFERRED CGM Product:**
   - ☐The member is using an insulin pump that is compatible with the requested non-preferred CGM Product
   - ☐The member has a history of trial and failure of the preferred CGM Products *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

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

Prescriber Signature:	**Date**:

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.)