health information designs

Continuous Glucose Monitoring Prior Authorization Form

Fax Completed Form to:
855-207-0250
For questions regarding this Prior authorization, call
866-773-0695

Prior Authorization Vendor for ND

ND Medicaid requires that patients receiving a prescription for continuous glucose monitoring to meet specific diagnosis and clinical criteria requirements. Criteria for CGM can be found the following location:

- The Preferred Diabetic Supplies List (PDSL) available at http://www.hidesigns.com/ndmedicaid/pdsl.pdf

Part I: TO BE COMPLETED BY PRESCRIBER/PRESCRIBER'S OFFICE

Recipient Name	Recipient Date of Birth	Recipient Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating physician)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Product:	**Diagnosis for this request:**		

List all current medications used for control of patient's blood glucose:

Qualifications for Coverage (please answer all of the questions below)	
Will the patient maintain regular provider visits to review glycemic control every 3-6 months?	□ YES □ NO
Is CGM data reviewed at provider's office visits?	□ YES □ NO
Will the provider use CGM data in the clinical decision-making process and document it in chart notes?	□ YES □ NO
Have chart notes been attached (from within the past 6 months) showing CGM data and documentation of clinical decision-making based on CGM data? (renewal requests only)	□ YES □ NO
Have chart notes been attached showing that the use of CGM has been recommended by a medical geneticist or an endocrinology specialist? (requests for off-label use only)	□ YES □ NO

Most recent Time in Range %: (renewal requests only)	**Patient's current A1c** (for patients with diabetes mellitus):

□ *I confirm that I have considered a generic or other alternative and that the requested drug is expected to result in the successful medical management of the recipient.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the patient's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #