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 Medicaid

ND Medicaid requires that members 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 www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE

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

Qualifications for Coverage for <u>all members</u> (please answer all the questions below)

1. Does the member have a life expectancy of over 12 months? ☐ YES ☐ NO
2. Does the member reside in a skilled nursing facility? ☐ YES ☐ NO

Complete the following section for members with <u>Type 1</u> OR <u>Type 2 Diabetes</u> *(not applicable when pregnant)*:

**Please provide the member's A1c for initial requests. An A1c OR Time-in-Range is required for renewal requests.*

1. Will the member maintain regular provider visits to review glycemic control every 3-6 months? ☐ YES ☐ NO
2. Will the provider review CGM data at provider office visits and use data to adjust/modify medication regimen to improve outcomes and not solely for hypoglycemia alerts? ☐ YES ☐ NO
3. Has the member been referred to a diabetic educator or specialist for treatment plan? ☐ YES ☐ NO

Member's current A1c %: _____ (Date: _____)
Member's most recent Time-in-Range %: _____ (Date: _____)

List all current medications used for control of member's blood glucose for members with <u>Type 2 Diabetes</u>:

☐ Humulin R U-500
☐ Insulin pump
☐ Other: _____

Complete the following section for members with <u>recurrent hypoglycemia</u> (off-label use):

Has the use of CGM for hypoglycemia been recommended by a medical geneticist or endocrinology specialist? ☐ YES ☐ NO

☐ *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 member.*

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 member'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 #