

**NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Continuous Glucose Monitors**



Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Transmitter/ Sensor Name: Dexcom G5 (Sensor only) Dexcom G6 FreeStyle Libre 2 FreeStyle Libre 14 day
9 Quantity for Transmitter (G6) _____ (Max 1) 10. Quantity for Dexcom (G5/G6) Sensor _____ (Max 3)
11. Quantity for Reader(Libre 14 day/Libre 2) _____ (Max 1) 12. Quantity for Sensors (Libre 14 day / Libre 2) _____ (Max 2)
13. Length of therapy (in days) for Dexcom G6 Transmitter, Decom G5 and G6 Sensor, Libre 14 day /Libre 2 Reader and Sensors:
 up to 30 days 60 days 90 days 120 days 180 days 365 days Other: _____
Max Length of Therapy for Initial Authorization is 180 days

For Dexcom G6 only:

14. Does the beneficiary have a smart device (phone/computer/tablet) to receive transmissions from the Dexcom G6?
 Yes No (Answering "NO" indicates that the beneficiary needs the Dexcom Receiver)

Clinical Information

For initial therapy, please answer questions 1-11, (max 6 months authorization):

1. Does the beneficiary have a diagnosis of insulin-dependent diabetes? Yes No
2. Has the beneficiary been using a standard BGM (blood glucose monitor) and testing four (4) or more times daily or using a non-therapeutic CGM? Yes No
3. Does the beneficiary require two (2) or more insulin injections daily? Yes No
4. Does the beneficiary's insulin treatment regimen require frequent adjustment based on standard BGM or non-therapeutic CGM testing? Yes No
5. Is the beneficiary and/or caregiver(s) willing and able to use the therapeutic CGM system as prescribed? Yes No
6. Has the beneficiary had a face-to-face encounter with the treating practitioner to evaluate the beneficiary's glycemic control and determine that criteria one through five (1-5) above have been met, within six months of the initial authorization? Yes No
7. Does the beneficiary use an external insulin pump? Yes No
8. For coverage of Dexcom G5 or G6; is the beneficiary age 2 years or older? Yes No
9. For coverage of FreeStyle Libre 14 day is the beneficiary age 18 years or older? Yes No
10. For coverage of FreeStyle Libre 2 is the beneficiary age 4 years or older? Yes No
11. For coverage of FreeStyle Libre 14 day, has the beneficiary tried using Dexcom G5, Dexcom G6, or Freestyle Libre 2? Yes No
If no, is there a clinical reason Dexcom G5, Dexcom G6, or Freestyle Libre 2 could not be used? Yes No
If yes, explain _____

For first reauthorization, please answer questions 12-14, (max 12-month authorization) DOCUMENTATION REQUIRED:

12. Has the beneficiary been using the CGM as prescribed? Yes No
13. Has the beneficiary been able to improve glycemic control? Yes No
14. Does the beneficiary continue to use as external insulin pump? Yes No

For Subsequent reauthorizations please answer questions 15-18, (max 12-month authorization) DOCUMENTATION REQUIRED

15. Has the beneficiary had a face-to-face encounter with the ordering practitioner to evaluate the efficacy of the CGM system no more than three (3) months prior to submission of this reauthorization request? Yes No
16. Has the beneficiary been using the CGM system as prescribed? Yes No
17. Has the beneficiary been able to maintain or further improve glycemic control? Yes No
18. Does the beneficiary continue to use an external insulin pump? Yes No

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.