CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

Prior Authorization Request Form: Dexcom Continuous Blood Glucose Monitors and Supplies

Please note: All information below is required to process this request. Monday – Friday: 8:00 AM to 4:30 PM Eastern.
Phone: 1-866-287-6156 | Fax: 1-866-839-2372 | www.carefirstchpdc.com

Patient Information (required)			Provider Information (required)		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth (Must be age 2 and older):	Sex: Male Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Medicaid ID:			Physician Signature:		
PHYSICIAN COMPLETES					

Please select Sensor AND/OR Transmitter/Receiver and indicate quantity:

Sensors:

☐ **Dexcom G6** **qty_____per 30 days**

Transmitters/Receivers:

☐ **Dexcom G6** **qty_____per 30 days**
☐ **Receiver G6** **Max qty 1 per 365 days**

1. What is the patient's diagnosis?

☐ Type 1 diabetes mellitus
☐ Type 2 diabetes mellitus
☐ Other diagnosis ***(please specify)***: _____

2. **Duration of Approval: How often to submit Prior Authorizations**.

☐ Initial authorization approval: Submit Authorization again in 3 Months.
☐ Continuation authorization: Submit authorization again in 1 Year.
☐ Receiver Authorization: Submit authorization again in 1 year.

This program is funded in part by the Government of the District of Columbia Department of Health Care Finance

PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

CareFirst BlueCross BlueShield
Community Health Plan
District of Columbia
1100 New Jersey Ave SE
Suite 840
Washington, D.C. 20003
www.carefirstchpdc.com

Prior Authorization Request Form:
Dexcom Continuous Blood Glucose Monitors and Supplies

CareFirst Community Health Plan District of Columbia

ABARCA

Documentation Requirements (e.q. Labs, Medical Record, Special Studies)

3. Please ensure proper documentation is included.

☐ Patient has completed or is enrolled in a comprehensive diabetic education program.
- ***(please specify)***:

☐ Patient has diabetes.
- Diagnosis date ___/___/_____

☐ Patient has a history of using a blood glucose monitor (BGM) with frequent (greater than 3 times daily) use.
- Prior Glucometer used and testing frequency ***(please specify)***: _____

☐ Patient is compliant with current medication regimen. (This will be confirmed through claims data)

☐ Patient's A1C is equal to or greater than 8% in the previous 3 months.
- Most Recent A1C level: _____ On date ___/___/___(Attach lab work)

☐ Patient has documented inadequate glycemic control despite compliance with frequent self-testing and fasting hyperglycemia (greater than 150 mg/dL) or frequent recurring episodes of severe hypoglycemia (less than 70 mg/dL)

☐ Patient has documented hypoglycemia unawareness, episodes of ketoacidosis or hospitalization for uncontrolled glucose levels. (Attach lab work)

4. **Approval Contingent upon**

☐ Enrollee's adherence will be evaluated via paid claims at the pharmacy.

☐ Recent A1C from previous 90 days with improvement.

5. **Contraindication/Exclusions/Discontinuation to consider prior to prescribing:**

☐ Sensor must be removed prior to:
- Magnetic Resonance Imaging (MRI)
- Computed Tomography (CT)
- High frequency electrical heat treatment

6. **Additional information:**
- Dosing recommendation for Adults and children: Replace sensor every 10 days.

DHCF The Department of Health Care Finance
WE ARE WASHINGTON GOVERNMENT OF THE DISTRICT OF COLUMBIA
DC MURIEL BOWSER, MAYOR
This program is funded in part by the Government of the District of Columbia Department of Health Care Finance