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

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 90 days**
☐ **Receiver G6** **Max qty 1 per 365 days**

1. What is the patient's diagnosis?

☐ Type 1 diabetes mellitus
☐ Type 2 diabetes mellitus
☐ Gestational diabetes

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

☐ Initial authorization approval: Submit Authorization again in 12 Months.
☐ Continuation authorization sensors and transmitters: Submit authorization again in 1 Year.
☐ Receiver Authorization: 1 per year.

DHCF GOVERNMENT OF THE DISTRICT OF COLUMBIA
MURIEL BOWSER, MAYOR

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

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Documentation Requirements (e.g. Labs, Medical Record, Clinical Notes)

Diagnosis of either1, 2, 3 and Clinical notes and lab results to support 4

1. Type 1 Diabetes Mellitus (T1D) and is using one or more daily insulin regimens.

2. Type II Type II Diabetes Mellitus (T2D) or Gestational Diabetes using one or more daily insulin regimen.

3. T2D not using insulin regimen but has a risk for preventable complications of diabetes and there is clear medical benefit from full-time or episodic CGM.

4. When the following criteria are met:

   - HbA1C greater than 7% within the last 6 months (attach lab results)
   - History of recurring hypoglycemia, history of severe glycemic excursions, a wide fluctuation in blood glucose before mealtime or a marked early morning increase in fasting flood sugar.
   - A beneficiary is using a home blood glucose monitor and conducting daily blood glucose monitoring tests. Verified using pharmacy claims information.
   - A beneficiary is expected to comply with a comprehensive diabetes training plan supervised by his or her treating provider and can manage and recognize the alarms and alerts of the device.
   - A beneficiary is willing to adhere to frequent blood glucose monitoring schedule.
   - A beneficiary had a visit with the treating practitioner, within the last six (6) months, to evaluate his/her diabetes control and determine that the above criteria has been met.
   - The request does not exceed health-plan quantity limit. Quantity limit on CGM may apply depending on the lifespan and wear time provided in the FDA approved or cleared product (sensor, transmitter, and receiver) information.

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