

**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:
City:		State:	Zip:	City:		State:
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.



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PLEASE PROCEED TO PAGE 2 FOR ADDITIONAL QUESTIONS

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Documentation Requirements (e.g. 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.



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