

Continuous Glucose Monitors

Mem	ber	Information
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1. Last Name: 2. First Name: 5. Gender: 3. Trillium ID #: 4. Date of Birth: 5. Gender: ?rescriber Information . . . 1. Prescriber Name: 2. NPI #: . 3. Requestor Name (Nurse/Office Staff): . . 4. Mailing Address:	Mer	nber Information			
Prescriber Information 1. Prescriber Name :	1.	Last Name:2. First Name:			
Prescriber Information 1. Prescriber Name :	3.	Trillium ID #:	4. Date of Birth:	5. Gender:	
3. Requestor Name (Nurse/Office Staff): 4. Mailing Address:					
3. Requestor Name (Nurse/Office Staff): 4. Mailing Address:	1.	Prescriber Name:	2. NPI #:		
Drug Information 1. Transmitter / Sensor Name: Dexcom G6 Dexcom G7 FreeStyle Libre 14 day FreeStyle Libre 2 FreeStyle Libre 3 2. Quantity for Transmitter (G6) (Max 1) 3. Quantity for Dexcom (G6/G7) Sensor (Max 3) 4. Quantity for Reader (Libre 14 day/Libre 2) (Max 1) 5. Quantity for Sensors (Libre 14 day / Libre 2 and Libre 3) (Max 2) 6. Length of therapy (in days) for Dexcom G6 Transmitter, G6 and G7 Sensor, Libre 14 day / Libre 2 Reader and Libre 3 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** 365 days Other: ************************************	3.	Requestor Name (Nurse/Office Staff)):		
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Max Length of Therapy for Initial Authorization is 180 days For Dexcom G6 and G7 only: 7. Does the member have a smart device (phone/computer/tablet) to receive transmissions from the Dexcom G6 or G7? Yes No (Answering *NO* indicates that the beneficiary needs the Dexcom Receiver) 2.Tinical Information For initial therapy, please answer questions 1-9, (max 6 months authorization): 1. Does the member have a diagnosis of insulin-dependent diabetes? U Yes No 2. Is the member 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? U Yes No 3. Has the member have a diagnosis of gestational diabetes? U Yes No 6. For coverage of Dexcom G6 or G7; is the member age 2 years or older? U Yes No 6. For coverage of FreeStyle Libre 14 day is the member age 18 years or older? U Yes No 7. One a. If 'NO', is there a clinical reason Dexcom G6, Dexcom G7, or Freestyle Libre 2 or 3? U Yes No 8. If 'YES', explain	2. 4.	Quantity for Transmitter (G6) (Quantity for Reader (Libre 14 day/Libre 2 (Max 2) Length of therapy (in days) for Dexcom G	Max 1) 3. Quantity for Dexcom (G6/G7) Sense) (Max 1) 5. Quantity for Sensors (L 6 Transmitter, G6 and G7 Sensor, Libre 14 day	or (Max 3) .ibre 14 day / Libre 2 and Libre 3) y /Libre 2 Reader and Libre 3 Sensors:	
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For initial therapy, please answer questions 1-9, (max 6 months authorization): 1. Does the member have a diagnosis of insulin-dependent diabetes? □ Yes □ No 2. Is the member and/or caregiver(s) willing and able to use the therapeutic CGM system as prescribed? □ Yes □ No 3. Has the member 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 4. Does the member use an external insulin pump? □ Yes □ No 5. Does the member have a diagnosis of gestational diabetes? □ Yes □ No 6. For coverage of Dexcom G6 or G7; is the member age 2 years or older? □ Yes □ No 7. For coverage of FreeStyle Libre 14 day is the member age 4 years or older? □ Yes □ No 8. For coverage of FreeStyle Libre 14 day, has the member tried using Dexcom G6 or G7, or Freestyle Libre 2 or 3? □ Yes □ No 9. For coverage of FreeStyle Libre 14 day, has the member age 4 years or older? □ Yes □ No 9. For coverage of FreeStyle Libre 14 day, has the member tried using Dexcom G6 or G7, or Freestyle Libre 2 or 3? □ Yes □ No 9. For coverage of FreeStyle Libre 14 day, has the member age 4 years or older? □ Yes □ No 9. If 'NO', is there a clinical reason Dexcom G6, Dexcom G7, or Freestyle Libre 2 or 3 could not be used? □ Yes □ No 10. Has the member been using the CGM as prescribed? □ Yes □ No 11. Has the member been able to improve glycemic control? □ Yes □ No	7.	r Dexcom G6 and G7 only: Does the member have a smart device (ph	none/computer/tablet) to receive transmissions	from the Dexcom G6 or G7?	
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 10. Has the member been using the CGM as prescribed? □ Yes □ No 11. Has the member been able to improve glycemic control? □ Yes □ No 12. Does the member continue to use as external insulin pump? □ Yes □ No For subsequent reauthorizations please answer questions 13-16, (max 12-month authorization) DOCUMENTATION REQUIRED 13. Has the member 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 14. Has the member been using the CGM system as prescribed? □ Yes □ No 15. Has the member been able to maintain or further improve glycemic control? □ Yes □ No 16. Does the member continue to use an external insulin pump? □ Yes □ No Signature of Prescriber: Date: 	1. 2. 3. 4. 5. 6. 7. 8. 9.	Does the member have a diagnosis of ins Is the member and/or caregiver(s) willing Has the member had a face-to-face enco determine that criteria one through five (1 Does the member use an external insulin Does the member have a diagnosis of ge For coverage of Dexcom G6 or G7; is the For coverage of FreeStyle Libre 14 day is For coverage of FreeStyle Libre 14 day is For coverage of FreeStyle Libre 14 day, h a. If 'NO', is there a clinical reason b. If 'YES', explain	sulin-dependent diabetes? Yes No and able to use the therapeutic CGM system a unter with the treating practitioner to evaluate t -5) above have been met, within six months of pump? Yes No estational diabetes? Yes No e member age 2 years or older? Yes No es the member age 18 years or older? Yes ore 3 is the member age 4 years or older? Yes as the member tried using Dexcom G6 or G7, Dexcom G6, Dexcom G7, or Freestyle Libre 2	No es No or Freestyle Libre 2 or 3? Yes No No Yes No No Yes No No Yes No No Yes No	
	10. 11. 12. Foi 13. 14.	Has the member been using the CGM as Has the member been able to improve glu Does the member continue to use as exter subsequent reauthorizations please an Has the member had a face-to-face enco than three (3) months prior to submission Has the member been using the CGM sy Has the member been able to maintain of	prescribed? Yes No ycemic control? Yes No ernal insulin pump? Yes No nswer questions 13-16, (max 12-month author unter with the ordering practitioner to evaluate of this reauthorization request? Yes No stem as prescribed? Yes No r further improve glycemic control? Yes No	orization) <u>DOCUMENTATION REQUIRED</u> : the efficacy of the CGM system no more	
	Si	gnature of Prescriber:	C	Date:	
(Prescriber Signature Mandatory)			riber Signature Mandatory)		
I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any				owledge, and I understand that any	

falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Pharmacy Prior Approval Request for Continuous Glucose Monitors Fax this form to PerformRx at (833) 726-7628 or call Pharmacy PA Call Center: (855) 662-0277