BlueCross BlueShield of North Carolina | HealthyBlue

Continuous Glucose Monitors Prior Authorization Form

Member information		
1. Member last name:	2. Member first name:	
3. Member ID #:	4. Member date of birth:	5. Member gender:

Prescriber information	
6. Prescribing provider's national provider ID (NPI) #:	
7. Requester contact information:	
Name:	
Phone:	Ext:

Drug information
8. Transmitter/sensor name: ☐ Dexcom G6 ☐ Dexcom G7 ☐ FreeStyle Libre 14 day ☐ FreeStyle Libre 2 ☐ FreeStyle Libre 3
9. Quantity for transmitter (G6) _____ (max one)
10. Quantity for Dexcom (G6/G7) sensor _____ (max three)
11. Quantity for reader (Libre 14 day/Libre 2 and Libre 3) _____ (max one)
12. Quantity for sensors (Libre 14 day/ Libre 2 and Libre 3) _____ (max two)
13. Length of therapy (in days) for Dexcom G6 transmitter, Decom G6 and G7 sensor, Libre 14 day/Libre 2 and Libre 3 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 and G7 only: 14. 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 member needs the Dexcom receiver.)

Clinical information
For initial therapy, please answer questions 1 to 9, (max. six-month 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 member's glycemic control and determine that criteria 1 and 2 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 beneficiary 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 18 years or older? ☐ Yes ☐ No

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Clinical information
8. For coverage of FreeStyle Libre 2 and Libre 3, is 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 If no, is there a clinical reason Dexcom G6, Dexcom G7, or Freestyle Libre 2 or 3 could not be used? ☐ Yes ☐ No If yes, explain:
For first reauthorization, please answer questions 10 to 12, (max. 12-month authorization) **Documentation required**
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 an external insulin pump? ☐ Yes ☐ No
For subsequent reauthorizations, please answer questions 13 to 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 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

Prescriber signature mandatory	
Signature of prescriber:	
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.	

Fax this form to **844-376-2318**
Healthy Blue Pharmacy PA Call Center: **844-594-5072**