OKLAHOMA Health Care Authority

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State of Oklahoma
SoonerCare
Continuous Glucose Monitor (CGM) Prior Authorization Form

Member Name:_____ **Date of Birth:**_____ **Member ID#:**_____

System Information

Please select CGM:
- ☐ Dexcom® G6
- ☐ Dexcom® G7
- ☐ FreeStyle® Libre
- ☐ FreeStyle® Libre 2
- ☐ FreeStyle® Libre 3

Please note: For CGM product continuation requests, please only list NDCs needed.

Please provide NDCs:
Receiver/Reader NDC:
_____
Sensor NDC:
_____
Transmitter NDC:
_____

Please indicate quantity:
Sensor:
qty:____ per ____days

Transmitter:
qty:____ per ____days

Billing Provider Information

Pharmacy NPI:_____ ***Pharmacy Name:***_____

Fill Date:_____ ***Pharmacy Phone:***_____ ***Pharmacy Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____

Clinical Information

Page 1 of 2 - Please complete and return all pages. ***Failure to complete all pages will result in processing delays.***

For Initial Authorization:

1. Please indicate diagnosis:
   - ☐ Type I diabetes mellitus (T1DM) meeting the criteria of American Diabetes Association (ADA) Standards of Medical Care in Diabetes, 2021
   - ☐ Type 2 diabetes mellitus (T2DM) meeting the criteria of ADA Standards of Medical Care in Diabetes, 2021
   - ☐ Gestational Diabetes mellitus meeting the criteria of ADA Standards of Medical Care in Diabetes, 2021
   - ☐ Pregnant with a medically documented diagnosis of T1DM
   - ☐ Other: _____
2. Date of diagnosis:_____
3. Is the member currently receiving insulin therapy? Yes☐ No☐
   A. If "No" to Question 3 and member is under 21 years of age, does the member have a history of problematic hypoglycemia with documentation of at least one of the following:
      - ☐ Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan. If yes, please provide the following:
        Glucose:_____mg/dL Date Taken:_____ Glucose:_____mg/dL Date Taken:_____
      - ☐ History of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia. If yes, please describe (including date and assistance required):
        _____
        _____

Fax completed prior authorization request form to **888-601-8461** or submit Electronic Prior Authorization through CoverMyMeds® or SureScripts. All requested data must be provided. Incomplete forms or forms without the chart notes will be returned. Pharmacy Coverage Guidelines are available at **AetnaBetterHealth.com/Oklahoma.**

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Initial Authorization, continued:

4. Has the treating practitioner had an in-person or telehealth visit with the member and/or family in the 6 months prior to ordering the CGM to evaluate their diabetes control and determined that the above criteria are met? Yes☐ No☐
5. Has the member and/or family member participated in age-appropriate diabetes education, training, and support prior to beginning CGM? Yes☐ No☐
6. **For FreeStyle Libre 3**, is the member capable and willing to use the FreeStyle Libre 3 mobile app and follow the FreeStyle Libre 3 *Instructions for Use*? Yes☐ No☐
7. **For FreeStyle Libre 3**, has the member ensured the FreeStyle Libre 3 mobile app is compatible with the member's specific smartphone? Yes☐ No☐

For Continued Authorization:

1. Has member been seen at least every 6 months following the initial prescription of the continuous glucose monitoring (CGM), by the CGM prescriber, to assess adherence to their CGM regimen and diabetes treatment plan? Yes☐ No☐
2. Has member received ongoing instruction and regular evaluation of technique, results, and their ability to use data from self-monitoring of blood glucose to adjust therapy? Yes☐ No☐
3. Do the member's prescriber records include documentation (i.e. trend graphs or CGM reports) demonstrating member's daily use of the CGM? Yes☐ No☐
4. Does the member need an additional receiver/reader? Yes☐ No☐
5. If an additional receiver/reader is being requested, please provide information to support why the member is unable to use the previously dispensed product:
   _____
6. If the receiver/reader is malfunctioning, has the manufacturer been contacted for product replacement? Yes☐ No☐

Additional information: _____

_____

_____

_____

Prescriber Signature:_____ **Date:**_____

(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.) *Please do not send in chart notes. Specific information/documentation will be requested if necessary.* ***Please complete and return all pages. Failure to complete all pages will result in processing delays.***

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