

AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; **fax to 1-305-671-0200.** No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Continuous Glucose Monitors (CGM)

Drug Requested: (Check below the CGM that applies, only ONE prior authorization form is required)

Formulary Preferred CGM's	
<input type="checkbox"/> FreeStyle Libre 14 Day System (Reader/Sensors)	<input type="checkbox"/> FreeStyle Libre 2 System (Reader/Sensors/Plus Sensors)
<input type="checkbox"/> Dexcom G6™ System (Receiver/Transmitter/Sensors)	<input type="checkbox"/> FreeStyle Libre 3 System (Reader/Sensors/Plus Sensors)
<input type="checkbox"/> Dexcom G7™ System (Receiver/Transmitter/Sensors)	
Non-Formulary – Provider please note: Medical Exception is required for all Non-Formulary CGM requests via submission of the following form: <u>Pharmacy Medical Necessity Request Form</u>	
<input type="checkbox"/> Eversense® (Sensor/Transmitter)	<input type="checkbox"/> Guardian™ 3 (Transmitter/Sensors)
<input type="checkbox"/> Guardian™ 4 (Transmitter/Sensors)	

PROVIDER PLEASE NOTE: Only one prior authorization form is required to be submitted for the request of any formulary or non-formulary CGM. If approved, an authorization will be entered for corresponding CGM supplies (e.g., readers, sensors, transmitters).

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy:** _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

- Will the member be discontinuing a previously prescribed continuous glucose monitor (CGM) device and/or supplies if approved for the requested CGM?

Yes **OR** No

- If yes, please list the CGM device and/or supplies that will be discontinued and the CGM device and/or supplies that will be initiated upon approval along with the corresponding effective date.

Medication to be discontinued: _____ **Effective date:** _____

Medication to be initiated: _____ **Effective date:** _____

Quantity Limits:

<u>Dexcom</u>	<u>Freestyle</u>
<ul style="list-style-type: none">• 1 receiver per 365 days• 3 sensors per 30 days• 1 transmitter per 90 days	<ul style="list-style-type: none">• 1 reader kit per 365 days• 2 sensors per 28 days• 2 plus sensors per 30 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Continuous Glucose Monitors – Long Term Use

Length of Authorization: 12 months

- Member requires Long-term CGM device indicated by **ALL** the following:
 - Diagnosis of **ONE** of the following:
 - Type 1 Diabetes Mellitus
 - Type 2 Diabetes Mellitus
 - Gestational Diabetes
 - Member requires at least one insulin injection per day or current use of an insulin pump

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❑ Continuous Glucose Monitors – Short Term Use

Length of Authorization: 1 month (30 days)

- ❑ Member requires Short-term CGM device indicated by **ALL** the following:
 - ❑ Diagnosis of **ONE** of the following:
 - ❑ Type 1 Diabetes Mellitus
 - ❑ Type 2 Diabetes Mellitus
 - ❑ Gestational Diabetes
 - ❑ Member must demonstrate at least **ONE** of the following:
 - ❑ Observed increase in blood glucose levels that takes place in the early morning (also known as The Dawn Phenomenon), known or suspected
 - ❑ Hypoglycemia unawareness (i.e., member does not have symptoms with hypoglycemia)
 - ❑ Nocturnal hypoglycemia, known or suspected
 - ❑ Postprandial hyperglycemia, known or suspected
 - ❑ Significant change to diabetes treatment regimen (e.g., initiation of insulin, change from multiple- dose insulin to insulin pump therapy)
 - ❑ Unexplained hyperglycemia
 - ❑ Member requires short term blood glucose monitoring (i.e., 7-14 days)

❑ Replacement Device

- ❑ Member has been previously approved for a CGM
- ❑ At least **ONE** of the following problems have occurred which limits the use of the member's current CGM
 - ❑ Abuse of equipment
 - ❑ Misuse of equipment
 - ❑ Reagent or instrument failure/defective devices
 - ❑ Defects in product design
 - ❑ Product instability
 - ❑ Failure to perform according to performance characterized in package insert
 - ❑ Incorrect test results (falsely elevated or decreased glucose results) that cause or contributed to an incorrect patient diagnosis and/or treatment
 - ❑ Unexplained quality control (QC) failures
 - ❑ Any other device problems that may compromise patient health or safety
- ❑ Provider or member must submit documentation that the member's current CGM device is not under warranty, including the date of warranty expiration

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Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.