SENTARA COMMUNITY PLAN
(MEDICAID)

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 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If information provided is not complete, correct, or legible, authorization will be delayed.**

Continuous Glucose Monitors (CGM)

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

Formulary Preferred CGMs	
❑ **FreeStyle Libre 14 Day System (Reader/Sensors)**	❑ **FreeStyle Libre 2 System (Reader/Sensors)**
❑ **Dexcom G6™ System (Receiver/Transmitter/Sensors)**	❑ **FreeStyle Libre 3 (Reader/Sensors)**
❑ **Dexcom G7™ System (Receiver/Transmitter/Sensors)**	
Non-Formulary CGMs – Provider please note: The below products are Medical Benefit Only and may be requested using the form located here	
❑ **Eversense® (Sensor/Transmitter) *medical benefit**	❑ **Guardian™ 3 (Transmitter/Sensors) *medical benefit**
❑ **Guardian™ 4 (Transmitter/Sensors) *medical benefit**	

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).**
- **FreeStyle Libre and Dexcom continuous glucose monitors (CGM) are covered under the pharmacy and medical benefit for Medicaid members. All other CGM requests will need to be submitted under the medical benefit for coverage determination.**

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

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

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

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

Weight: _____ **Date:** _____

Quantity Limits:

Dexcom	Freestyle
• 1 receiver per lifetime • 3 sensors per 30 days • 1 transmitter per 90 days	• 1 reader kit per lifetime • 2 sensors per 28 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 (1 year)

❑ Has the member been approved for a CGM device previously through the Sentara Health Plans medical department?

❑ Yes ❑ No

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- ❑ 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 a demanding insulin regimen of at least three or more insulin injections per day or current use of an insulin pump
- ❑ Member or guardian consistently monitors blood glucose three or more times per day
- ❑ Provider attests that the member is motivated and knowledgeable about use of CGMs, is adherent to diabetic treatment plan, and participates in ongoing education and support

❑ 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
- ❑ Member has been benefiting from the use of the CGM

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- ❑ At least **ONE** of the following problems have occurred which limits the use of the member's current CGM:
  - ❑ 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 is not under warranty, including the date of warranty expiration

*****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.****

***Approved by Pharmacy and Therapeutics Committee**: 5/18/2023
REVISED/UPDATED/REFORMATTED: ~~5/17/2023; 9/15/2023; 12/11/2023; 1/22/2024;~~ **2/28/2024**