

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 the information provided is not complete, correct, or legible, the authorization process can be delayed.

Continuous Glucose Monitors (CGM)

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

| Formulary Preferred CGMs | |
|--|--|
| <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 CGMs | |
| Provider please note: Medical Exception is required | |
| <input type="checkbox"/> Eversense® (Sensor/Transmitter) | <input type="checkbox"/> Guardian™ 3 (Transmitter/Sensors) |
| <input type="checkbox"/> Guardian™ 4 (Transmitter/Sensors) | <input type="checkbox"/> Minimed™ Instinct Sensors |
| <input type="checkbox"/> Simpler™ Sensors | <input type="checkbox"/> Symplera™ Sync 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 Sentara #: _____ 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 Name/Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

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

Quantity Limits:

| <u>Dexcom</u> | <u>Freestyle</u> |
|---|--|
| <ul style="list-style-type: none">• 1 receiver per year• 3 sensors per 30 days• 1 transmitter per 90 days | <ul style="list-style-type: none">• 1 reader kit per year• 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.

- ☐ Has the member been approved for a CGM device previously through the Sentara Health Plans medical department? ☐ Yes ☐ No

Continuous Glucose Monitors

Length of Authorization: 12 months (1 year)

- ☐ Member is 2 years of age or older
- ☐ Member has been diagnosed with diabetes by their primary care physician, or another licensed health care practitioner authorized to make such a diagnosis
- ☐ Member is being treated with insulin and/or the member has a history of problematic hypoglycemia
- ☐ Member's treating practitioner concluded that the member (or member's caregiver) has had sufficient training using the continuous glucose monitor prescribed as evidenced by the prescription provided.
- ☐ The continuous glucose monitor has been prescribed in accordance with the Food and drug Administration indications for use

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Replacement Device

- ☐ Member has been previously approved for a CGM
- ☐ Member has been benefiting from the use of the CGM
- ☐ 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

Reauthorization: 12 months. 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.

- ☐ Member continues to meet the relevant criteria identified in the initial criteria
- ☐ Member is being monitored for benefit of using the continuous glucose monitor by way of follow up every 6 months in the first 18 months of use or annually after the first 18 months of use

*****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.****