SENTARA HEALTH PLANS

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.**

This is a group specific benefit

Continuous Glucose Monitors (CGM) & Subcutaneous Insulin Pump Supplies

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

Formulary Preferred CGM's	
❑ **FreeStyle Libre 14 Day System (Reader/Sensors)**	❑ **FreeStyle Libre 2 System (Reader/Sensors/Plus Sensors)**
❑ **Dexcom G6™ System (Receiver/Transmitter/Sensors)**	❑ **FreeStyle Libre 3 System (Reader/Sensors/Plus Sensors)**
❑ **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: Pharmacy Medical Necessity Request Form	
❑ **Eversense® (Sensor/Transmitter)**	❑ **Guardian™ 3 (Transmitter/Sensors)**
❑ **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).

FOR INSULIN PUMP SUPPLIES ONLY: As of 1/1/2025, subcutaneous insulin pumps and combinations devices are now covered under the medical benefit for VCUHS members, however, subcutaneous insulin pump supplies will remain covered under the pharmacy benefit for VCUHS members only. All other Sentara Health Plans members will need to submit requests for coverage determination of subcutaneous insulin pumps, combination devices & supplies under the medical benefit.

(Continued on next page)

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 #: _____

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:

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 • 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.

(Continued on next page)

❑ Continuous Glucose Monitors – Long Term Use

Length of Authorization: Indefinite

- ❑ 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
  - ❑ 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)

(Continued on next page)

❑ Subcutaneous Insulin Pump Supplies

Group Specific Benefit: VCUHS Members Only

FOR INSULIN PUMP SUPPLIES ONLY: Subcutaneous insulin pumps and combinations devices are now covered under the medical benefit for VCUHS members, however, subcutaneous insulin pump supplies will remain covered under the pharmacy benefit for VCUHS members only. All other Sentara Health Plans members will need to submit requests for coverage determination of subcutaneous insulin pumps, combination devices & supplies under the medical benefit.

ALL the following criteria must be met:

- ❑ Provider is an endocrinologist
- ❑ Provider must submit **ALL** the following documentation:
  - ❑ Confirmation of Diagnosis
  - ❑ Two weeks of current blood glucose results obtained within the last 30 days
  - ❑ Glycosylated hemoglobin (HbA1c) lab result obtained within the last 6 months
- ❑ 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)
  - ❑ Metabolic control is inadequate, due to inconsistencies in insulin absorption with mixed insulin regimens
  - ❑ Member requires a demanding insulin regimen of at least three or more insulin injections per day
  - ❑ Optimal glycemic control has not been achieved as demonstrated by a recurrent, severe hypoglycemic event that may have resulted in hospitalization
- ❑ Provider attests that the member is motivated and knowledgeable about use of requested device, is adherent to diabetic treatment plan, and participates in ongoing education and support
- ❑ For members diagnosed with Gestational Diabetes, at least **ONE** of the following criteria must be met:
  - ❑ Member requires two or more insulin injections daily
  - ❑ Member has microalbuminuria >20 mcg/min
  - ❑ Member has proteinuria >120 mg/day
  - ❑ Member has a history of nephropathy
  - ❑ Member has a history of retinopathy

❑ Replacement Device

- ❑ Member has been previously approved for a CGM

(Continued on next page)

- ❑ 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

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.__