

# 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.**

### 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"/> <b>FreeStyle Libre 14 Day System (Reader/Sensors)</b>  | <input type="checkbox"/> <b>FreeStyle Libre 2 System (Reader/Sensors/Plus Sensors)</b> |
| <input type="checkbox"/> <b>Dexcom G6™ System (Receiver/Transmitter/Sensors)</b>  | <input type="checkbox"/> <b>FreeStyle Libre 3 System (Reader/Sensors/Plus Sensors)</b> |
| <input type="checkbox"/> <b>Dexcom G7™ System (Receiver/Transmitter/Sensors)</b>  |  |
| <b>Non-Formulary – Provider please note: Medical Exception is required for all Non-Formulary CGM requests via submission of the following form:</b><br><a href="#" style="color: blue; text-decoration: underline;">Pharmacy Medical Necessity Request Form</a> |  |
| <input type="checkbox"/> <b>Eversense® (Sensor/Transmitter)</b>   | <input type="checkbox"/> <b>Guardian™ 3 (Transmitter/Sensors)</b>                      |
| <input type="checkbox"/> <b>Guardian™ 4 (Transmitter/Sensors)</b>   |  |

**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 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"><li>• 1 receiver per 365 days</li><li>• 3 sensors per 30 days (10-day sensors)</li><li>• 2 sensors per 30 days (15-day sensors)</li><li>• 1 transmitter per 90 days</li></ul> | <ul style="list-style-type: none"><li>• 1 reader kit per 365 days</li><li>• 2 sensors per 28 days</li><li>• 2 plus sensors per 30 days</li></ul> |

**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.\**