OKLAHOMA Health Care Authority

State of Oklahoma
SoonerCare
Continuous Glucose Monitor (CGM) Prior Authorization Form

Member Name:_____ **Date of Birth:**_____ **Member ID#:**_____

System Information

☐ **Dexcom G6®**
Receiver NDC:_____
Transmitter NDC:_____
Sensor NDC:_____

Please indicate quantity:
Sensor qty:____ per ____days
Transmitter qty:____ per ____days

☐ **FreeStyle® Libre**
Reader NDC:_____
Sensor NDC:_____

Please indicate quantity:
Sensor qty:____ per ____days

☐ **FreeStyle® Libre 2**
Reader NDC:_____
Sensor NDC:_____

Please indicate quantity:
Sensor qty:____ per ____days

Billing Provider Information

Pharmacy NPI:_____ ***Pharmacy Name:***_____

Fill Date:_____ ***Pharmacy Phone:***_____ ***Pharmacy Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____

Clinical Information

Page 1 of 2 - Please complete and return all pages. ***Failure to complete all pages will result in processing delays.***

For Initial Authorization:

1. Please indicate diagnosis:
   - ❑ Type I diabetes mellitus (T1DM) meeting the criteria of American Diabetes Association (ADA) Standards of Medical Care in Diabetes, 2019
   - ❑ Other: _____
2. Has member been using self-monitoring blood glucose (SMBG; finger sticks)? Yes☐ No☐
3. Has member been performing frequent blood glucose testing (≥4/day)? Yes☐ No☐
4. Please indicate how member is receiving insulin therapy:
   a. Is member insulin-treated with multiple daily injections (≥3/day)? Yes☐ No☐
   b. Is member using insulin pump therapy? Yes☐ No☐
5. Does member's insulin treatment regimen require frequent adjustment by the member or provider on the basis of SMBG or continuous glucose monitoring (CGM) testing results? Yes☐ No☐
6. In the past 6 months, has member experienced 2 or more Level 2 hypoglycemic episodes [glucose <54mg/dL (3.0mmol/L)] in spite of appropriate therapy? Yes☐ No☐
   a. If "Yes" to Question 6 above, please provide the following:
      i. Glucose:_____mg/dL Date Taken:_____
      ii. Glucose:_____mg/dL Date Taken:_____
7. In the past 6 months, has member experienced 1 Level 3 glucose episode (severe event characterized by altered mental and/or physical status requiring assistance as a result of hypoglycemia or ketoacidosis, hyperglycemia) in spite of appropriate therapy? Yes☐ No☐
   a. If "Yes" to Question 7 above, please describe:_____
      _____
8. Has the treating practitioner had an in-person or telehealth visit with the member and/or family within in the 6 months prior to ordering the CGM to evaluate their diabetes control and determined that the above criteria are met? Yes☐ No☐
9. Has the member and/or family member participated in age-appropriate diabetes education, training, and support prior to beginning CGM? Yes☐ No☐

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
University of Oklahoma College of Pharmacy
Pharmacy Management Consultants
Product Based Prior Authorization Unit
Fax: 1-800-224-4014
Phone: 1-800-522-0114 Option 4

OKLAHOMA
Health Care Authority

State of Oklahoma
Oklahoma Health Care Authority
Continuous Glucose Monitor (CGM) Prior Authorization Form

Member Name:_____ Date of Birth:_____ Member ID#:_____

Clinical Information

Page 2 of 2 - Please complete and return all pages. ***Failure to complete all pages will result in processing delays.***

For Continued Authorization:

1. Has member been seen at least every 6 months following the initial prescription of the continuous glucose monitoring (CGM), by the CGM prescriber, to assess adherence to their CGM regimen and diabetes treatment plan? Yes☐ No☐
2. Has member received ongoing instruction and regular evaluation of technique, results, and their ability to use data from self-monitoring of blood glucose to adjust therapy? Yes☐ No☐
3. Do the member's prescriber records include documentation (i.e. trend graphs or CGM reports) demonstrating member's daily use of the CGM? Yes☐ No☐
4. Does member continue to meet **Initial Authorization** criteria #1-5 (including criteria #3 when CGM is not being utilized)? Yes☐ No☐

Prescriber Signature:_____ Date:_____
(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.) *Please do not send in chart notes. Specific information/documentation will be requested if necessary.*

Please complete and return <u>all</u> pages. ***Failure to complete all pages will result in processing delays.***

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*