WellCare
Beyond Healthcare. A Better You.

NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for Continuous Glucose Monitors

Beneficiary Information

01. Beneficiary Last Name: _____ 02. Beneficiary First Name: _____
03. Beneficiary ID #: _____ 04. Beneficiary Date of Birth: _____05. Beneficiary Gender: ___

Prescriber Information

06. Prescribing Provider NPI #: _____
07. Requester Contact Information:
Name: _____ Phone #: _____ Ext. _____

Monitor Information

08. Transmitter / Sensor Name: ☐ Dexcom G6 ☐ FreeStyle Libre 2 ☐ FreeStyle Libre 14 day
09. Quantity for transmitter (G6) _____ (max 1)
10. Quantity for Dexcom (G6) sensor _____ (max 3)
11. Quantity for reader (Libre 2 / Libre 14 day) _____ (max 1)
12. Quantity for sensors (Libre 2 / Libre 14 day) _____ (max 2)
13. Length of therapy* (in days) for Dexcom G6 transmitter, G6 sensor, or Libre 2 / Libre 14 day reader and sensors:
☐ Up to 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days ☐ Other: _____

*Max length of therapy for initial authorization is 180 days

For Dexcom G6 only:
14. Does the beneficiary have a smart device (phone, computer, tablet) to receive transmissions from the Dexcom G6?
☐ **Yes** ☐ **No** (Answering "NO" indicates that the beneficiary needs the Dexcom receiver)

Clinical Information

For initial therapy, please answer questions 1-10 (max 6 months authorization):
01. Does the beneficiary have a diagnosis of insulin-dependent diabetes? ☐ **Yes** ☐ **No**
02. Does the beneficiary require two or more insulin injections daily? ☐ **Yes** ☐ **No**
03. Does the beneficiary's insulin treatment regimen require frequent adjustment based on standard blood glucose monitor (BGM) or non-therapeutic continuous glucose monitor (CGM) testing? ☐ **Yes** ☐ **No**
04. Is the beneficiary and/or caregiver(s) willing and able to use the therapeutic CGM system as prescribed?
☐ **Yes** ☐ **No**
05. Has the beneficiary had a face-to-face encounter with the treating practitioner within six months of the initial authorization to evaluate the beneficiary's glycemic control and to determine if clinical criteria one through four have been met? ☐ **Yes** ☐ **No**
06. Does the beneficiary use an external insulin pump? ☐ **Yes** ☐ **No**
07. For coverage of Dexcom G6, is the beneficiary age 2 years or older? ☐ **Yes** ☐ **No**
08. For coverage of FreeStyle Libre 14 day, is the beneficiary age 18 years or older? ☐ **Yes** ☐ **No**
09. For coverage of FreeStyle Libre 2, is the beneficiary age 4 years or older? ☐ **Yes** ☐ **No**
10. For coverage of FreeStyle Libre 14 day, has the beneficiary tried using Dexcom G6 or Freestyle Libre 2?
☐ **Yes** ☐ **No**
10a. If no, is there a clinical reason Dexcom G6 or Freestyle Libre 2 could not be used? ☐ **Yes** ☐ **No**

Reason: _____

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For first reauthorization, please answer questions 11-13 (DOCUMENTATION REQUIRED):**
11. Has the beneficiary been using the CGM as prescribed? ☐ **Yes** ☐ **No**
12. Has the beneficiary been able to improve glycemic control? ☐ **Yes** ☐ **No**
13. Does the beneficiary continue to use an external insulin pump? ☐ **Yes** ☐ **No**

**Max 12-month authorization

For subsequent reauthorizations*, please answer questions 14-17 (DOCUMENTATION REQUIRED):**
14. Has the beneficiary had a face-to-face encounter with the ordering practitioner to evaluate the efficacy of the CGM system no more than three months prior to submission of this reauthorization request? ☐ **Yes** ☐ **No**
15. Has the beneficiary been using the CGM system as prescribed? ☐ **Yes** ☐ **No**
16. Has the beneficiary been able to maintain or further improve glycemic control? ☐ **Yes** ☐ **No**
17. Does the beneficiary continue to use an external insulin pump? ☐ **Yes** ☐ **No**

***Max 12-month authorization

Signature of Prescriber: _____ Date: _____
(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to **1-800-678-3189**
Pharmacy PA Call Center: **1-866-799-5318**