WellCare®

NC Medicaid
Pharmacy Prior Approval Request for
Continuous Glucose Monitors

Beneficiary Information

1. Beneficiary Last Name: _____ 2. First Name: _____
3. Beneficiary ID #: _____ 4. Beneficiary Date of Birth: _____ 5. Beneficiary Gender: _____

Prescriber Information

6. Prescribing Provider NPI #: _____
7. Requester Contact Information - Name: _____ Phone #: _____ Ext. _____

Drug Information

8. Transmitter/ Sensor Name: ☐ Dexcom G6 ☐ Dexcom G7 ☐ FreeStyle Libre 14 day ☐ FreeStyle Libre 2 ☐ FreeStyle Libre 3
9 Quantity for Transmitter (G6) _____ (Max 1) 10. Quantity for Dexcom (G6/G7) Sensor _____ (Max 3)
11. Quantity for Reader(Libre 14 day/Libre 2) _____ (Max 1) 12. Quantity for Sensors (Libre 14 day / Libre 2 and Libre 3) _____ (Max 2)
13. Length of therapy (in days) for Dexcom G6 Transmitter, Decom G6 and G7 Sensor, Libre 14 day /Libre 2 Reader and Sensors and Libre 3 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 and G7 only:
14. Does the beneficiary have a smart device (phone/computer/tablet) to receive transmissions from the Dexcom G6 or G7?
☐ **Yes** ☐ **No** (Answering "NO" indicates that the beneficiary needs the Dexcom Receiver)

Clinical Information

For initial therapy, please answer questions 1-9, (max 6 months authorization):
1. Does the beneficiary have a diagnosis of insulin-dependent diabetes? ☐ **Yes** ☐ **No**
2. Is the beneficiary and/or caregiver(s) willing and able to use the therapeutic CGM system as prescribed? ☐ **Yes** ☐ **No**
3. Has the beneficiary had a face-to-face encounter with the treating practitioner to evaluate the beneficiary's glycemic control and determine that criteria one and two(1 and 2) above have been met, within six months of the initial authorization? ☐ **Yes** ☐ **No**
4. Does the beneficiary use an external insulin pump? ☐ **Yes** ☐ **No**
5. Does the beneficiary have a diagnosis of gestational diabetes? ☐ **Yes** ☐ **No**
6. For coverage of Dexcom G6 or G7; is the beneficiary age 2 years or older? ☐ **Yes** ☐ **No**
7. For coverage of FreeStyle Libre 14 day is the beneficiary age 18 years or older? ☐ **Yes** ☐ **No**
8. For coverage of FreeStyle Libre 2 and Libre 3 is the beneficiary age 4 years or older? ☐ **Yes** ☐ **No**
9. For coverage of FreeStyle Libre 14 day, has the beneficiary tried using, Dexcom G6 or G7, or Freestyle Libre 2 or 3? ☐ **Yes** ☐ **No**
If no, is there a clinical reason Dexcom G6, Dexcom G7, or Freestyle Libre 2 or3 could not be used? ☐ **Yes** ☐ **No**
If yes, explain _____

For first reauthorization, please answer questions 10-12, (max 12-month authorization) DOCUMENTATION REQUIRED:
10. Has the beneficiary been using the CGM as prescribed? ☐ **Yes** ☐ **No**
11. Has the beneficiary been able to improve glycemic control? ☐ **Yes** ☐ **No**
12. Does the beneficiary continue to use as external insulin pump? ☐ **Yes** ☐ **No**

For Subsequent reauthorizations please answer questions 13-16, (max 12-month authorization) DOCUMENTATION REQUIRED
13. 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 (3) months prior to submission of this reauthorization request? ☐ **Yes** ☐ **No**
14. Has the beneficiary been using the CGM system as prescribed? ☐ **Yes** ☐ **No**
15. Has the beneficiary been able to maintain or further improve glycemic control? ☐ **Yes** ☐ **No**
16. Does the beneficiary continue to use an external insulin pump? ☐ **Yes** ☐ **No**

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 (800) 678-3189 Pharmacy PA Call Center: (866) 799-5318