VERMONT
Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~Continuous Glucose Monitors~

Prior Authorization Request Form

In order for members to receive Medicaid coverage for medications that require prior authorization, the prescriber must complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
Name: _____
Physician NPI: _____
Specialty: _____
Phone#: _____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#: _____
Date of Birth: _____ Sex: _____
Patient's Phone: _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

Effective 10/1/21, all claims must go through Retail Pharmacy (Complete Pharmacy Info above). Medicare crossover claims are excluded from this requirement and may continue to use the DME channel.

Prior authorization will apply to all CGM supplies including transmitters, receivers, and sensors. Please note that many new devices do not require the use of a separate receiver, and patients may prefer to use a "smart device" such as a cell phone, in lieu of a receiver. Approval of non-preferred products will be limited to cases where the CGM is directly integrated with the patient's insulin pump. The make and model of pump must be documented on the prior authorization form.

Product Requested: ☐Dexcom G6 ☐Dexcom G7 ☐Freestyle Libre Pro (10 day) ☐ Freestyle Libre 14 day ☐ Freestyle Libre 2 ☐Freestyle Libre 3

☐Medtronic Guardian Connect (non-preferred) ☐ Other:_____

Supplies Requested: ☐Receiver (initial prescription) ☐ Transmitter ☐ Sensors Length of Therapy:_____

Patient has a diagnosis of Diabetes Mellitus AND meets the following criteria:

☐ Patient requires multiple daily injections of a rapid/short acting insulin or is on an insulin pump.
Make and Model of insulin pump: _____

Re-authorization:

☐ Documentation has been submitted showing evidence of compliance to CGM (e.g. log data and/or office visit notes)

Other Information/ Comments: _____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescribers Signature: Date:

CHANGE HEALTHCARE