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 information 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 14 day ☐ Freestyle Libre 2
☐Freestyle Libre 3
☐Medtronic Guardian Connect (non-preferred) Make and Model of insulin pump:_____

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

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

☐ Patient requires treatment with insulin. Insulin regimen: _____

OR

☐ Patient has a history of problematic hypoglycemia AND medications that could contribute to hypoglycemia (e.g. sulfonylureas, meglitinides) have been discontinued AND there is documentation of at least one of the following: Recurrent level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple attempts to adjust medication(s) and/or modify the diabetes treatment plan OR a history of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third party assistance for treatment of hypoglycemia

Re-authorization:

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

☐ Claims history shows a reduction in test strip utilization. (Initial Renewal Only).
*For those using the same number of test strips after initiating a CGM, clinical justification needs to be provided for the continued use of a CGM.

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: