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 beneficiaries 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: _____

Please select provider type (only one): ☐ DME (Medical Benefit) ☐ Retail Pharmacy (Complete Pharmacy Info above)

The following MUST be completed for DME/MEDICAL BENEFIT requests:

- HCPCS A-code (check all that apply) ☐ A9276 (sensors) ☐ A9277 (transmitter) ☐ A9278 (receiver)
- DME Provider: Name_____ NPI#_____ Medicaid ID#_____.

Prior authorization is required for both new and existing patients and 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 ☐Freestyle Libre Pro (10 day) ☐ Freestyle Libre 14 day

☐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 BOTH criteria below:

☐ Patient requires use of insulin at least three times per day or is on an insulin pump.
Make and Model of insulin pump: _____

☐ Frequent adjustments to treatment regimen are necessary based on blood glucose testing results

AND At least one of the following are documented for NEW requests (documentation must be submitted):

☐ Hypoglycemic unawareness

☐ Recurrent episodes of severe hypoglycemia (<55 mg/dL) or hyperglycemia (>300 mg/dL) persisting despite adjustments to therapy based on previous short-term CGM or self-monitoring.

☐ Nocturnal hypoglycemia

☐ Patient cannot achieve glycemic control (defined as HbA1c ≤ 7%) despite good compliance and understanding of current treatment plan. (Note: pharmacy claims will be reviewed for the past 6 months to assess compliance). HbA1c results:_____Date obtained:_____

☐ Recurring diabetic ketoacidosis

CHANGE HEALTHCARE

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

Re-authorization:

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

AND

☐ Documentation has been submitted showing evidence of improved glycemic control (defined by patient achieving a hemoglobin A1c ≤ 7% or a reduction in of ≥ 0.5% from baseline) and/or reduced incidences of hypoglycemia or hyperglycemia. HbA1c results:_____Date obtained:_____

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: