Continuous Glucose Monitor Prior Authorization Form

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Medicaid
Bureau for Medical Services

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID # | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (MI)

Prescriber Address (Street) | (City) | (State) | (Zip)

Prescriber 10-Digit NPI # | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

Pharmacy 10-Digit NPI # | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Product (select one):

- ☐ Freestyle Libre 2
- ☐ Freestyle Libre 2 Plus
- ☐ Freestyle Libre 3
- ☐ Freestyle Libre 3 Plus
- ☐ Dexcom G6
- ☐ Dexcom G7
- ☐ Other (please specify) _____

Components (select all that are needed):

- ☐ Sensors
- ☐ Transmitters (Dexcom G6 Only)
- ☐ Receiver/Reader

Diagnosis:

ICD-10 Diagnosis Code:

Directions (please include the frequency at which each component will be changed/replaced):

Document all medications ***currently*** prescribed for glycemic control for this patient. Complete all fields for each medication.

Medication Name	Strength	Directions for Use (including dose and dosing frequency)	Start Date

Attach additional pages as necessary...

If this continuous glucose monitor system is approved, will the patient continue to receive blood glucose test strips and lancets? If yes, please indicate the test strips and lancets that will be prescribed and the new frequency of use *(up to 50 test strips/lancets per 90 days can be authorized upon request for PRN use)*. ☐ Yes ☐ No

Name of Test Strips Requested	Directions for use	Quantity	Days Supply

Name of Lancets Requested	Directions for use	Quantity	Days Supply

If requesting a nonpreferred test strip and/or lancet, please provide justification for why a preferred test strip/lancet could not be prescribed.

For Reauthorization/Continuation Requests Only:

Please attach the summary report printout from the patient's continuous glucose monitor from the last 30 days.

Other pertinent information:

Attestation: Your signature (manual or electronic) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature

Date: (MM/DD/YYYY)