AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Continuous Glucose Monitors (CGM)

Drug Requested: (Check below the CGM that applies, only **ONE** prior authorization form is required)

Formulary Preferred CGM's	
❑ **FreeStyle Libre 14 Day System (Reader/Sensors)**	❑ **FreeStyle Libre 2 System (Reader/Sensors)**
❑ **Dexcom G6™ System (Receiver/Transmitter/Sensors)**	❑ **FreeStyle Libre 3 (Reader/Sensors)**
❑ **Dexcom G7™ System (Receiver/Transmitter/Sensors)**	
Non-Formulary – Provider please note: A pharmacy medical necessity request form must be submitted for all Non-Formulary CGM requests	
❑ **Eversense® (Sensor/Transmitter)**	❑ **Guardian™ 3 (Transmitter/Sensors)**
❑ **Guardian™ 4 (Transmitter/Sensors)**	

PROVIDER PLEASE NOTE: Only one prior authorization form is required to be submitted for the request of any formulary or non-formulary CGM. If approved, an authorization will be entered for corresponding CGM supplies (e.g., readers, sensors, transmitters).

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

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DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Name/Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

- Will the member be discontinuing a previously prescribed continuous glucose monitor (CGM) if approved for the requested CGM?

  ❑ Yes **OR** ❑ No

- If yes, please list the CGM that will be discontinued and the CGM that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

Quantity Limits:

Dexcom	Freestyle
• 1 receiver per lifetime • 3 sensors per 30 days • 1 transmitter per 90 days	• 1 reader kit per lifetime • 2 sensors per 28 days

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ Continuous Glucose Monitors – Long Term Use

Length of Authorization: Indefinite

- ❑ Member requires Long-term CGM device indicated by **ALL** the following:
  - ❑ Diagnosis of **ONE** of the following:
    - ❑ Type 1 Diabetes Mellitus
    - ❑ Type 2 Diabetes Mellitus
    - ❑ Gestational Diabetes
  - ❑ Member requires a demanding insulin regimen of at least three or more insulin injections per day or current use of an insulin pump
  - ❑ Member or guardian consistently monitors blood glucose three or more times per day
  - ❑ Provider attests that the member is motivated and knowledgeable about use of CGMs, is adherent to diabetic treatment plan, and participates in ongoing education and support

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❑ Continuous Glucose Monitors – Short Term Use

Length of Authorization: 1 month (30 days)

- ❑ Member requires Short-term CGM device indicated by **ALL** the following:
  - ❑ Diagnosis of **ONE** of the following:
    - ❑ Type 1 Diabetes Mellitus
    - ❑ Type 2 Diabetes Mellitus
    - ❑ Gestational Diabetes
  - ❑ Member must demonstrate at least **ONE** of the following:
    - ❑ Observed increase in blood glucose levels that takes place in the early morning (also known as The Dawn Phenomenon), known or suspected
    - ❑ Hypoglycemia unawareness (i.e., member does not have symptoms with hypoglycemia)
    - ❑ Nocturnal hypoglycemia, known or suspected
    - ❑ Postprandial hyperglycemia, known or suspected
    - ❑ Significant change to diabetes treatment regimen (e.g., initiation of insulin, change from multiple- dose insulin to insulin pump therapy)
    - ❑ Unexplained hyperglycemia
  - ❑ Member requires short term blood glucose monitoring (i.e., 7-14 days)

❑ Replacement Device

- ❑ Member has been previously approved for a CGM device
- ❑ At least **ONE** of the following problems have occurred which limits the use of the member's current CGM device
  - ❑ Abuse of equipment
  - ❑ Misuse of equipment
  - ❑ Reagent or instrument failure/defective devices
  - ❑ Defects in product design
  - ❑ Product instability
  - ❑ Failure to perform according to performance characterized in package insert
  - ❑ Incorrect test results (falsely elevated or decreased glucose results) that cause or contributed to an incorrect patient diagnosis and/or treatment
  - ❑ Unexplained quality control (QC) failures
  - ❑ Any other device problems that may compromise patient health or safety
- ❑ Provider or member must submit documentation that the member's current CGM device is not under warranty, including the date of warranty expiration

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Not all drugs may be covered under every Plan
If a drug is non-formulary on a Plan, documentation of medical necessity will be required.
*****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*****
****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****