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 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

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- ❑ 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

❑ 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 or insulin pump device
- ❑ At least **ONE** of the following problems have occurred which limits the use of the member's current CGM or insulin pump 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

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- ❑ 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 or insulin pump device is not under warranty, including the date of warranty expiration

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.****

Approved by Pharmacy and Therapeutics Committee: 3/15/2022
REVISED/UPDATED/REFORMATTED: ~~2/16/2022; 3/29/2022; 5/6/2022; 6/15/2022; 6/16/2022; 3/2/2023; 5/17/2023; 9/15/2023; 12/11/2023; 1/26/2024;~~ **7/01/2024**