Tufts Health RITogether Continuous Glucose Monitors Prior Authorization Request Form

Fax completed form to: 617.673.0988

Today's date: _____

This form applies to members of Tufts Health RITogether (RI Medicaid Plan). Participating providers should use this form to request authorization for continuous glucose monitors (CGMs). Dexcom 6 is the preferred product and is available through the pharmacy. Members utilizing the Medtronic Guardian Device specifically as part of an Artificial Pancreas Device System (APDS) can continue to obtain from DME (Fax: 617.972.9409). Call 888.301.4093 with any questions about CGMs.

MEMBER INFORMATION

Name: _____ ID: _____ DOB:_____

PRESCRIBER INFORMATION

Name:_____ Specialty:_____

NPI#:_____ Phone: _____Fax:_____

CGM INFORMATION

☐ Dexcom G6 (Preferred) ☐ Freestyle Libre ☐ Medtronic Guardian ☐ Other: _____

Rationale for CGM other than Dexcom G6:

_____

_____

Products Requested:

☐ Receiver

☐ Transmitter ☐ Sensor Pack Frequency: _____

Treatment status: ☐ New start ☐ Continuation of therapy

CLINICAL INFORMATION

Diagnosis: ☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other, please specify: _____

Please answer the following questions:

1. How many insulin injections does the member require per day?
   Please specify: _____
2. Does the member require the use of an insulin pump?
   ☐ Yes ☐ No
3. How many times does the member perform blood sugar testing via fingerstick per day?
   Please specify: _____
4. Is the member compliant with the prescribed insulin regimen and dietary management?
   ☐ Yes ☐ No
5. Does the member have an awareness of hypoglycemic symptoms such as sweating, tremor, palpitations, tachycardia, confusion and lethargy?
   ☐ Yes ☐ No

6. Does the member have recurrent episode of severe hypoglycemia defined as a glucose level of less than 50 mg/dl, which are not attributable to some type of dosing error (e.g., taking insulin too far in advance of a meal)?
   ☐ Yes ☐ No
7. Is the member expected to comply with a comprehensive diabetes treatment plan supervised by his or her treating provider, and is capable of recognizing the alarms and alerts of the device?
   ☐ Yes ☐ No

RENEWAL REQUEST

1. Does the member continue to use and require the device and does the device continue to meet the member's needs?
   ☐ Yes ☐ No
2. When was the member's most recent appointment with the endocrinologist?

   Date of last appointment: _____/_____/_____

REPLACEMENT DEVICE/EQUIPMENT

1. When did the member first obtain the device?

   Date: _____/_____/_____
2. Is the device inoperable or ineffective due to damage resulting from events outside control of the member?
   ☐ Yes ☐ No
3. Is there documentation supporting consistent compliance with the device and an ongoing need for it as an integral part of the member's diabetes management program?
   ☐ Yes ☐ No
4. Can a replacement not be obtained through the supplier or manufacturer (i.e., warranty has expired)?
   ☐ Yes ☐ No
5. Is the replacement device similar to the previous device, without additional features or enhancements?
   ☐ Yes ☐ No

OTHER HISTORY RELEVANT TO THIS REQUEST

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I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber Signature: _____ Date: _____