OKLAHOMA
Health Care Authority

State of Oklahoma
SoonerCare
Continuous Glucose Monitor (CGM) Prior Authorization Form

Member Name:_____ **Date of Birth:**_____ **Member ID#:**_____

System Information

Please select CGM:	**Please provide NDCs:**	**Please indicate quantity:**
☐ Dexcom® G6 ☐ Dexcom® G7 ☐ FreeStyle® Libre ☐ FreeStyle® Libre 2 ☐ FreeStyle® Libre 3 ***Please note: For CGM product continuation requests, please only list NDCs needed.***	Receiver/Reader NDC: _____ Sensor NDC: _____ Transmitter NDC: _____	Sensor: qty:____ per ____days Transmitter: qty:____ per ____days

Billing Provider Information

Pharmacy NPI:_____ ***Pharmacy Name:***_____

Fill Date:_____ ***Pharmacy Phone:***_____ ***Pharmacy Fax:***_____

Prescriber Information

Prescriber NPI:_____ ***Prescriber Name:***_____

Prescriber Phone:_____ ***Prescriber Fax:***_____

Clinical Information

Page 1 of 2 - Please complete and return all pages. ***Failure to complete all pages will result in processing delays.***

For Initial Authorization:

1. Please indicate diagnosis:
   - ☐ Type I diabetes mellitus (T1DM) meeting the criteria of American Diabetes Association (ADA) Standards of Medical Care in Diabetes, 2021
   - ☐ Type 2 diabetes mellitus (T2DM) meeting the criteria of ADA Standards of Medical Care in Diabetes, 2021
   - ☐ Gestational Diabetes mellitus meeting the criteria of ADA Standards of Medical Care in Diabetes, 2021
   - ☐ Pregnant with a medically documented diagnosis of T1DM
   - ☐ Other: _____

If member is younger than 21 years of age with a diagnosis of T2DM or 21 years of age or older with a diagnosis of T1DM, T2DM, or gestational diabetes please complete questions 2 through 10:

2. Date of diagnosis:_____
3. Has member been using self-monitoring blood glucose (SMBG; finger sticks)? Yes☐ No☐
4. Has member been performing frequent blood glucose testing (≥4/day)? Yes☐ No☐
5. Please indicate how member is receiving insulin therapy:
   a. Is member insulin-treated with multiple daily injections (≥3/day)? Yes☐ No☐
   b. Is member using insulin pump therapy? Yes☐ No☐
6. Does member's insulin treatment regimen require frequent adjustment by the member or provider on the basis of SMBG or continuous glucose monitoring (CGM) testing results? Yes☐ No☐
7. In the past 6 months, has member experienced 2 or more Level 2 hypoglycemic episodes [glucose <54mg/dL (3.0mmol/L)] in spite of appropriate therapy? Yes☐ No☐
   a. If "Yes" to Question 7 above, please provide the following:
      i. Glucose:_____mg/dL Date Taken:_____
      ii. Glucose:_____mg/dL Date Taken:_____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:	CONFIDENTIALITY NOTICE
University of Oklahoma College of Pharmacy Pharmacy Management Consultants Product Based Prior Authorization Unit Fax: 1-800-224-4014 Phone: 1-800-522-0114 Option 4	*This document, including any attachments, contains information which is confidential or privileged. If you are not the intended recipient, be aware that any disclosure, copying, distribution, or use of the contents of this information is prohibited. If you have received this document in error, please notify the sender immediately by telephone to arrange for the return of the transmitted documents or to verify their destruction.*

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Initial Authorization, continued:

8. In the past 6 months, has member experienced 1 Level 3 glucose episode (severe event characterized by altered mental and/or physical status requiring assistance as a result of hypoglycemia or ketoacidosis, hyperglycemia) in spite of appropriate therapy? Yes☐ No☐
   a. If "Yes" to Question 8 above, please describe (including assistance required):
      _____
      _____
   b. Date of Level 3 glucose episode:_____
9. Has the treating practitioner had an in-person or telehealth visit with the member and/or family within in the 6 months prior to ordering the CGM to evaluate their diabetes control and determined that the above criteria are met? Yes☐ No☐
10. Has the member and/or family member participated in age-appropriate diabetes education, training, and support prior to beginning CGM? Yes☐ No☐
11. **For FreeStyle Libre 3**, is the member capable and willing to use the FreeStyle Libre 3 mobile app and follow the FreeStyle Libre 3 *Instructions for Use*? Yes☐ No☐
12. **For FreeStyle Libre 3**, has the member ensured the FreeStyle Libre 3 mobile app is compatible with the member's specific smartphone? Yes☐ No☐

For Continued Authorization:

1. Has member been seen at least every 6 months following the initial prescription of the continuous glucose monitoring (CGM), by the CGM prescriber, to assess adherence to their CGM regimen and diabetes treatment plan? Yes☐ No☐
2. Has member received ongoing instruction and regular evaluation of technique, results, and their ability to use data from self-monitoring of blood glucose to adjust therapy? Yes☐ No☐
3. Do the member's prescriber records include documentation (i.e. trend graphs or CGM reports) demonstrating member's daily use of the CGM? Yes☐ No☐
4. Does member continue to meet **Initial Authorization** criteria #1-6 (including criteria #3 when CGM is not being utilized)? Yes☐ No☐
5. Does the member need an additional Dexcom G6 receiver, FreeStyle Libre reader, or FreeStyle Libre 2 reader ? Yes☐ No☐
6. If an additional Dexcom G6 receiver, FreeStyle Libre reader, or FreeStyle Libre 2 reader is being requested, please provide information to support why the member is unable to use the previously dispensed product:
   _____
7. If the Dexcom G6 receiver, FreeStyle Libre reader, or FreeStyle Libre 2 reader is malfunctioning, has the manufacturer been contacted for product replacement? Yes☐ No☐

Prescriber Signature:_____ **Date:**_____
(By signature, the physician confirms the criteria information above is accurate and verifiable in patient records.) *Please do not send in chart notes. Specific information/documentation will be requested if necessary.*
Please complete and return all pages. Failure to complete all pages will result in processing delays.

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