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:
- ☐ Dexcom® G6
- ☐ Dexcom® G7
- ☐ FreeStyle® Libre
- ☐ FreeStyle® Libre 2
- ☐ FreeStyle® Libre 3

Please note: For CGM product continuation requests, please only list NDCs needed.

Please provide NDCs:
Receiver/Reader NDC:
_____
Sensor NDC:
_____
Transmitter NDC:
_____

Please indicate quantity:
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: _____
2. Date of diagnosis:_____
3. Is the member currently receiving insulin therapy? Yes☐ No☐
   A. If "No" to Question 3 and member is under 21 years of age, does the member have a history of problematic hypoglycemia with documentation of at least one of the following:
      - ☐ Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan. If yes, please provide the following:
        Glucose:_____mg/dL Date Taken:_____ Glucose:_____mg/dL Date Taken:_____
      - ☐ History of one level 3 hypoglycemic event (glucose <54mg/dL (3.0mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia. If yes, please describe (including date and assistance required):
        _____
        _____

PLEASE PROVIDE THE INFORMATION REQUESTED AND RETURN TO:
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

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Initial Authorization, continued:

4. Has the treating practitioner had an in-person or telehealth visit with the member and/or family in the 6 months prior to ordering the CGM to evaluate their diabetes control and determined that the above criteria are met? Yes☐ No☐
5. Has the member and/or family member participated in age-appropriate diabetes education, training, and support prior to beginning CGM? Yes☐ No☐
6. **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☐
7. **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 the member need an additional receiver/reader? Yes☐ No☐
5. If an additional receiver/reader is being requested, please provide information to support why the member is unable to use the previously dispensed product:
   _____
6. If the receiver/reader is malfunctioning, has the manufacturer been contacted for product replacement? Yes☐ No☐

Additional information: _____

_____

_____

_____

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.***

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.*