



Updated: 09/2023

DMMA Approved: 09/2023

**Request for Prior Authorization for Continuous Glucose Monitoring Systems**

Website Form – [www.highmarkhealthoptions.com](http://www.highmarkhealthoptions.com)

Submit request via: Fax - 1-855-476-4158

All requests for Continuous Glucose Monitoring Systems require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

**Continuous Glucose Monitoring Systems Prior Authorization Criteria:**

For all requests for Continuous Glucose Monitoring Systems all of the following criteria must be met:

- Member must be insulin treated with at least one daily injection of insulin or a covered continuous insulin infusion pump.
- For non-preferred systems, the member has had a trial and failure of a preferred system or submitted a clinical reason for not having a trial of a preferred system
- **Duration of Approval:** 12 months

Coverage may be provided for any non-FDA labeled indication if it is determined that the use is a medically accepted indication supported by nationally recognized pharmacy compendia or peer-reviewed medical literature for treatment of the diagnosis(es) for which it is prescribed. These requests will be reviewed on a case by case basis to determine medical necessity.



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**Continuous Glucose Monitoring Systems  
PRIOR AUTHORIZATION FORM**

Please complete and fax all requested information below including any progress notes, laboratory test results, or chart documentation as applicable to Highmark Health Options Pharmacy Services. **FAX:** (855) 476-4158  
If needed, you may call to speak to a Pharmacy Services Representative.  
**PHONE:** (844) 325-6251 Monday through Friday 8:00am to 7:00pm

**PROVIDER INFORMATION**

Requesting Provider:	NPI:
Provider Specialty:	Office Contact:
Office Address:	Office Phone:
	Office Fax:

**MEMBER INFORMATION**

Member Name:	DOB:	
Member ID:	Member weight:	Height:

**REQUESTED DRUG INFORMATION**

Medication:	Strength:	
Directions:	Quantity:	Refills:
Is the member currently receiving requested medication? <input type="checkbox"/> Yes <input type="checkbox"/> No    Date Medication Initiated:		
Is this medication being used for a chronic or long-term condition for which the medication may be necessary for the life of the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No		

**Billing Information**

This medication will be billed:  at a pharmacy **OR**  
 medically (if medically please provide a JCODE: \_\_\_\_\_)

Place of Service:  Hospital     Provider's office     Member's home     Other

**Place of Service Information**

Name:	NPI:
Address:	Phone:

**MEDICAL HISTORY (Complete for ALL requests)**

- 1) Is the member insulin treated with daily injections of insulin or a covered continuous insulin infusion pump?  
 Yes     No

**CURRENT or PREVIOUS THERAPY**

Medication Name	Strength/ Frequency	Dates of Therapy	Status (Discontinued & Why/Current)

**SUPPORTING INFORMATION or CLINICAL RATIONALE**


**Prescribing Provider Signature**

**Date**

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