

Updated: 01/2024 DMMA Approved: 01/2024

Request for Prior Authorization for Continuous Glucose Monitoring Systems Website Form – 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 re	equested information below	including a	ny progres	s 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:	Member Name: DOB:				
Member ID:		Member weight: Height:			
REQUESTED DRUG INFORMATION					
Medication: Strength:					
Directions:		Quantity: Refills:			
Is the member currently receiving	requested medication?	Yes No		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? Yes 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. Infospital Place of Service Information					
Name: NPI:					
Address:			Phone:		
Address. Filolic.			i none.		
MEDICAL HISTODY (Complete for ALL megaseta)					
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 Providence	ler Signature			Date	