



Updated: 05/2025

DMMA Approved: 06/2025

**Request for Prior Authorization for Continuous Glucose Monitoring Systems and Insulin Pumps**

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

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

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

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 (see criteria for pharmacy benefit pump below).
- Non-preferred CGM products are not payable under the pharmacy benefit. They must be billed under the Durable Medical Equipment benefit
- **Duration of Approval:** 12 months

For all requests for Insulin Pumps covered under the pharmacy benefit all of the following criteria must be met:

- Member must have a diagnosis of diabetes
- Member must require insulin treatment
- Non-preferred pumps are not payable under the pharmacy benefit. They must be billed under the Durable Medical Equipment benefit.
- **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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**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)**

For Continuous Glucose Monitors:  
1) Is the member insulin treated with daily injections of insulin or a covered continuous insulin infusion pump?  
 Yes  No

For Insulin Pumps:  
1) Diagnosis: \_\_\_\_\_ ICD 10 code: \_\_\_\_\_  
2) Does the member require insulin treatment?  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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