

Prior Authorization Criteria  
**Continuous Glucose Monitor Systems**

All requests for continuous glucose monitor systems require a prior authorization and will be screened for medical necessity and appropriateness using the criteria listed below.

Members with historical pharmacy claims data meeting the following criteria will receive automatic authorization at the pharmacy point of service without the requirement for documentation of additional information. If pharmacy claims data cannot obtain the criteria below, documentation will be required to indicate the member meets the criteria. Claims will automatically adjudicate on-line, without a requirement to submit for prior authorization when the following criteria is met:

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

- Concurrent use of insulin treatment or history of insulin utilization within the last 90 days.
- For non-formulary systems, the member has had a trial and failure of a formulary system or submitted a clinical reason for not having a trial of a formulary system
- **Initial Duration of Approval:** 12 months
- **Reauthorization criteria**
  - Member continues to be on insulin treatment.
- **Reauthorization 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.

When criteria are not met, the request will be forwarded to a Medical Director for review. The physician reviewer must override criteria when, in their professional judgment, the requested medication is medically necessary.



Updated: 04/2022  
PARP Approved: 04/2022

**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 Wholecare Pharmacy Services. **FAX:** (888) 245-2049  
If needed, you may call to speak to a Pharmacy Services Representative. **PHONE:** (800) 392-1147 Mon – Fri 8:30am to 5:00pm

**PROVIDER INFORMATION**

Requesting Provider:	Provider NPI:
Provider Specialty:	Office Contact:
State license #:	Office NPI:
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:

**Billing Information**

This medication will be billed:  at a pharmacy **OR**  medically, 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 currently (within the last 90 days) using insulin?  
 Yes  No

**CURRENT or PREVIOUS THERAPY**

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

**REAUTHORIZATION**

Is the member still using insulin?  Yes  No

**SUPPORTING INFORMATION or CLINICAL RATIONALE**


**Prescribing Provider Signature**

**Date**

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