Highmark Wholecare
Pharmacy Division
Phone 800-392-1147 Fax 888-245-2049

I. Requirements for Prior Authorization of Continuous Glucose Monitoring Products

A. Prescriptions That Require Prior Authorization

All prescriptions for Continuous Glucose Monitoring Products must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Continuous Glucose Monitoring Product, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Has **one** of the following:
   a. Use of an antidiabetic medication within the last 90 days
   b. A diagnosis of diabetes;
   AND

2. For a non-preferred Continuous Glucose Monitoring Product, **one** of the following:
   a. Has a history of therapeutic failure of the preferred Continuous Glucose Monitoring Products
   b. Requires a non-preferred Continuous Glucose Monitoring Product for compatibility with their insulin delivery device

   See the Preferred Drug List for the list of preferred Continuous Glucose Monitoring Products at: https://papdl.com/preferred-drug-list;

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Continuous Glucose Monitoring Product. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

Approvals of requests for prior authorization of prescriptions for Continuous Glucose Monitoring Products will be approved for 12 months.

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CONTINUOUS GLUCOSE MONITORING PRODUCTS

PRIOR AUTHORIZATION FORM *(form effective 1/5/2026)*

☐New request ☐Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product(s) requested:

☐Receiver/reader: _____ Quantity: _____

☐Transmitters: _____ Quantity: _____ per _____ days Refills: _____

☐Sensors: _____ Quantity: _____ per _____ days Refills: _____

☐Other: _____ Quantity: _____ per _____ days Refills: _____

Diagnosis *(submit documentation)*:	Dx code (*required*):

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

1. **For ALL requests for a Continuous Glucose Monitoring (CGM) Product:**
   - ☐The beneficiary has a diagnosis of diabetes
   - ☐The beneficiary has a diagnosis other than diabetes for which CGM is medically necessary – *submit documentation supporting the medical necessity of CGM for this beneficiary*

2. **For requests for a NON-PREFERRED CGM Product:**
   - ☐The beneficiary is using an insulin delivery device that is compatible with the requested non-preferred CGM Product
   - ☐The beneficiary has a history of trial and failure of the preferred CGM Products *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION

Prescriber Signature:	**Date**: