BlueCross BlueShield Federal Employee Program.

CONTINUOUS GLUCOSE MONITORS (CGM) PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		
PHYSICIAN COMPLETES					

Continuous Glucose Monitors (CGM)

NOTE: Form must be completed in its **entirety** for processing

Please select the monitor you are requesting:

❑Dexcom G6 **❑Dexcom G7** **❑Freestyle Libre 2** **❑Freestyle Libre 3** **❑Freestyle Libre 14 Day**

1. **Dexcom Request**: Does the patient need more than 9 sensors every 90 days? ❑Yes***** ❑No
   If YES, please specify: _____ sensors every 90 days
2. **Dexcom G6 Request**: Does the patient need more than 1 transmitter every 90 days? ❑Yes***** ❑No
   If YES, please specify: _____ transmitters every 90 days
3. **Freestyle Libre Request**: Does the patient need more than 6 sensors every 84 days? ❑Yes***** ❑No
   If YES, please specify: _____ sensors every 84 days
4. Does the patient have a diagnosis of type 1 or type 2 diabetes mellitus (DM)? ***Please select answer below:***
   ❑Type 1 diabetes mellitus (DM)
   a. Has the patient been utilizing a CGM device or app for the last 6 months? ❑Yes ❑No
   ❑Type 2 diabetes mellitus (DM)
   a. Has the patient been utilizing a CGM device or app for the last 6 months? ❑Yes ❑No*****
   If NO, please select answer the following questions:
   i. Is the patient receiving *****GLP-1 agonist injections? ❑Yes ❑No*****
   GLP-1 Receptor Agonists: Adlyxin, Bydureon, Byetta, Mounjaro, Ozempic, Soliqua, Trulicity, Victoza, Xultophy
   If NO, please answer the following questions:
   1) Is the patient insulin dependent? ❑Yes ❑No
   2) Does the patient require more than 3 injections of insulin per day? ❑Yes ❑No
   3) Has the patient been using an insulin pump? ❑Yes***** ❑No
   If YES, has the patient required frequent insulin dosage adjustments for at least 6 months? ❑Yes ❑No
   ii. Is the patient's diabetes considered uncontrolled? ❑Yes***** ❑No
   If YES, in the past 2 months, is there a documented average glucose self-testing frequency of at least 5 times per day? ❑Yes ❑No
   iii. What is the patient's HbA1c? _____ %
   iv. Does the patient have frequent hypoglycemic episodes? ❑Yes ❑No
   v. Has the patient completed a comprehensive diabetes education program? ❑Yes ❑No
   vi. Will the patient provide the device readings with the physician or healthcare provider as part of overall diabetic management? ❑Yes ❑No

   ❑No, other diagnosis *(please specify)*: _____
5. Does the patient require more than 540 blood glucose test strips every 90 days to be used to supplement device readings? ❑Yes ❑No

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***