US Family Health Plan
Prior Authorization Request Form for
Continuous Glucose Monitoring (CGM) Systems
(Dexcom G6, FreeStyle Libre 2, FreeStyle Libre 3)

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Initial and renewal prior authorization expires after 1 year. For renewal of therapy an initial USFHP prior authorization approval is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Has the patient received this product under the USFHP PHARMACY benefit in the last 6 months? This does not include use of a CGM through other methods including DME. *Please choose "No" if the patient did not previously have a USFHP approved PA for the requested product.*	☐ Yes (prior use will be verified) Proceed to question **2**	☐ No Proceed to question **8**
2. Is there confirmation that the patient has seen an endocrinologist or diabetes management expert at least once within the past year? • Diabetes management expert is defined as: licensed independent practitioner experienced in the management of insulin dependent diabetics requiring basal and bolus dosing or a pump and familiar with the operation and reports necessary for proper management of continuous glucose monitoring systems. This is a self-certification.	☐ Yes proceed to question **3**	☐ No **STOP** **Coverage not approved**
3. Is there confirmation that the patient has utilized CGM daily?	☐ Yes proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Will the provider and patient assess the usage of self-monitoring of blood glucose (SMBG) test strips at every visit, with the goal of minimizing/discontinuing use?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Does the patient continue to agree to share data with managing healthcare professional for the purposes of clinical decision making?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**

6. Does the patient have Type 2 diabetes mellitus?	☐ Yes proceed to question **7**	☐ No **Sign and date below**
7. Does the patient continue to require daily basal and prandial insulin injections?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
8. Is the requested product prescribed by an endocrinologist or diabetes management expert? • Diabetes management expert is defined as: licensed independent practitioner experienced in the management of insulin dependent diabetics requiring basal and bolus dosing or a pump and familiar with the operation and reports necessary for proper management of continuous glucose monitoring systems. This is a self-certification.	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Does the patient have a diagnosis of Type 1 diabetes mellitus OR Type 2 diabetes mellitus?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Is the patient using basal and prandial insulin injections?	☐ Yes proceed to question **14**	☐ No proceed to question **11**
11. Is the patient using a continuous subcutaneous insulin infusion (such as insulin pump)?	☐ Yes proceed to question **14**	☐ No proceed to question **12**
12. Does the patient have a diagnosis of Type 2 diabetes mellitus?	☐ Yes proceed to question **13**	☐ No **STOP** **Coverage not approved**
13. Is the patient receiving insulin therapy and has a history of severe hypoglycemia episodes requiring medical intervention?	☐ Yes proceed to question **14**	☐ No **STOP** **Coverage not approved**
14. Has documentation been submitted to confirm the patient's diagnosis? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes proceed to question **15**	☐ No **STOP** **Coverage not approved**
15. Has documentation been submitted to confirm the patient's medication history, including use of insulin? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes proceed to question **16**	☐ No **STOP** **Coverage not approved**

16. Has documentation been submitted to confirm completion of a comprehensive diabetes education program for the patient? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes proceed to question **17**	☐ No **STOP** **Coverage not approved**
17. Has documentation been submitted to confirm that the patient agrees to wear CGM as directed? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes proceed to question **18**	☐ No **STOP** **Coverage not approved**
18. Has documentation been submitted to confirm that the patient agrees to share device readings with managing healthcare professional for overall diabetes management? NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	☐ Yes proceed to question **19**	☐ No **STOP** **Coverage not approved**
19. Will the provider and patient assess the usage of self-monitoring of blood glucose (SMBG) test strips, with the goal of minimizing/discontinuing use?	☐ Yes proceed to question **20**	☐ No **STOP** **Coverage not approved**
20. What is the requested product?	☐ Dexcom G6 - proceed to question **21** ☐ FreeStyle Libre 2 - proceed to question **22** ☐ FreeStyle Libre 3 – proceed to question **22**	
21. Is the patient 2 years of age or older?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
22. Is the patient 4 years of age or older?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date