US Family Health Plan
Prior Authorization Request Form for
Continuous Glucose Monitoring (CGM) Systems **(Dexcom G6, Dexcom G7, FreeStyle Libre 2, FreeStyle Libre 3, FreeStyle Libre 3 Plus sensor)**

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. Is the requested medication being used for diabetes?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Has the patient received this product under the TRICARE 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 TRICARE approved PA for the requested product.*	☐ Yes (prior use will be verified) proceed to question **3**	☐ No proceed to question **8**
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 proceed to question **8**
7. Does the patient continue to require daily basal or prandial insulin injections?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Is the patient using basal or prandial insulin injections?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Please document the following: **Insulin product: _____ Date last filled _____** **Note: the patient must have filled an insulin prescription within the past 180 days.** **Sign and date below**		

Step 3

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

_____ _____

Prescriber Signature Date

[12 Feb 2025]