West Virginia Medicaid
Drug Prior Authorization Form
http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx

Continuous Glucose Monitor Prior Authorization Form

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) ______ (First) ______ (M) ___ WV Medicaid 11 Digit ID# ______ Date of Birth (MM/DD/YYYY) ______

Prescriber Name (Last) ______ (First) ______ (MI) ___

Prescriber Address (Street) ______ (City) ______ (State) West Virginia (Zip) ______

Prescriber 10-Digit NPI# ______ Phone # (111-222-3333) ______ Fax # (111-222-3333) ______

Pharmacy Name (if applicable) ______

Pharmacy Address (Street) ______ (City) ______ (State) West Virginia (Zip) ______

Pharmacy 10-Digit NPI# ______ Phone # (111-222-3333) ______ Fax # (111-222-3333) ______

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Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Product (Select one)

- ☐ Dexcom G6 Continuous Glucose Monitor
- ☐ Freestyle Libre 14-day
- ☐ Freestyle Libre 2

Components (Select all that are needed)

- ☐ Sensors
- ☐ Transmitters (Dexcom Only)
- ☐ Receiver/Reader

Diagnosis ______

ICD-10 Diagnosis Code ______

Directions: ______

Document all medications currently prescribed for glycemic control for this patient. For each medication, include the medication name, dose, directions for use, start date, and (if no longer taking) the end date along with the reason for discontinuing.

______

Is the patient currently self-testing his/her blood glucose? ☐ Yes - **Attach glucose logs from the last 90 days (required)** ☐ No - Not Approved

Indicate the reason the patient requires continuous glucose monitoring (Check all that apply):

- ☐ Documented history of recurring hypoglycemia
- ☐ Wide fluctuations in pre-meal glucose
- ☐ History of severe glycemic excursions
- ☐ Experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200mg/dL
- ☐ Currently using an insulin pump AND continuing to need frequent dosage adjustments
- ☐ Currently using an insulin pump AND experiencing recurring episodes of severe hypoglycemia (50mg/dL)
- ☐ Other (Please describe, in detail):

If this continuous glucose monitor system is approved, will the patient continue to receive blood glucose test strips and lancets? If yes, please indicate the test strips and lancets that will be prescribed and the new frequency of use. ☐ Yes ☐ No

Other Pertinent Information:

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature

Date: (MM/DD/YYYY)