STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

CT Medical Assistance Program
CGM (Continuous Glucose Monitor) Pharmacy Prior Authorization (PA) Request Form

This form must be completed by the prescribing provider. If the form is missing information, the PA will not be processed.

Prescriber Information	Patient Information
Prescriber's NPI:	Patient Medicaid ID Number:
Prescriber Name:	Patient Name:
Phone #:	Patient DOB:
Fax #:	Primary ICD Diagnosis Code:

Please Select Only ONE System Per Prior Authorization Request Form:

☐ **Dexcom G6 System**	Dexcom G6 Receiver (NDC 08627-0091-11) Dexcom G6 Transmitter (NDC 08627-0016-01) Dexcom G6 Sensor (NDC 08627-0053-03)
☐ **Dexcom G7 System**	Dexcom G7 Receiver (NDC 08627-0078-01) Dexcom G7 Sensor/Transmitter (NDC 08627-0077-01)
☐ **Freestyle Libre 2 System**	Freestyle Libre 2 Reader (NDC 57599-0803-00) Freestyle Libre 2 Sensor (NDC 57599-0800-00)
☐ **Freestyle Libre 3 System**	Freestyle Libre 3 Reader (NDC 57599-0820-00) Freestyle Libre 3 Sensor (NDC 57599-0818-00)

Clinical Information

1.	**For patients currently established on CGM Therapy:** Are the following statements TRUE: 1. There is assessment by the treating provider at least every 12 months and 2. There is documented evidence of compliance with the device (e.g. data download, documentation of review of data download) to which proper use and continued benefit has been established by diabetes care team	☐ **Yes** ☐ **No**
2.	**For patients NOT currently established on CGM therapy:** Are the below 2 statements TRUE: 1.) Patient is managed by an endocrinologist or clinician with expertise treating individuals with diabetes 2.) Patient satisfies one or more of the criteria listed below: a. Patient is diagnosed with Type 1 Diabetes b. Patient is diagnosed with Type 2 Diabetes AND is treated with insulin AND has patterns of hypoglycemia or hyperglycemia c. Patient is using insulin pump for insulin delivery d. Patient has gestational diabetes or is pregnant and a CGM is recommended by the treating provider	☐ **Yes** ☐ **No**

If you answered 'NO' to the applicable question above as it relates to your patient, a Letter of Medical Necessity (LMN) must be reviewed for consideration. Please provide all relevant information relating to the medical necessity (see Conn. Gen. Stat § 17b-259b(a)) for this patient. Submit request, via email, to rx.lmn@ct.gov.

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.
I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1-13 and 4a-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the client is under my clinic's/practice's ongoing care. I certify that I am a practitioner and hold a current, unrestricted license that allows me to prescribe medication and that I am enrolled in the CT Medical Assistance Program.

Prescriber Signature: _____ **Date:** _____