PRIORITY PARTNERS
7231 Parkway Dr., Suite 100
Hanover, MD 21076

JOHNS HOPKINS
HEALTH PLANS

Prior Authorization

JOHNS HOPKINS HEALTH PLANS

CGM Devices - Priority Partners MCO

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Johns Hopkins Health Plans at **1-410-424-4607**.
Please contact Johns Hopkins Health Plans at **1-888-819-1043** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of CGM Devices - Priority Partners MCO.

Drug Name
(specify drug) _____

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Is this request for continuation of therapy? Y N

[Note: The use of physician samples, or manufacturer product discounts, does not guarantee coverage under the provisions of the medical and/or pharmacy benefit. All pertinent criteria must be met in order to be eligible for benefit coverage.]

[If no, then skip to question 3.]

2. Has the patient had a clinical improvement from using the Continuous Glucose Monitoring (CGM) device? Y N

	[Note: Documentation must be submitted.]		
	[No further questions.]		
3.	Does the patient have the diagnosis of type 1 diabetes or type 2 diabetes?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
4.	Does the patient require 3 or more insulin injections daily or the use of an insulin pump to maintain blood glucose control?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
5.	Does the patient have at least one of the following: A) frequent severe hypoglycemia (blood glucose level less than 50 mg/dl), B) hypoglycemic unawareness requiring another person's assistance for glucose rescue action, C) hemoglobin A1c greater than or equal to 7 percent?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
6.	Has the patient or caregiver received diabetes education and training on using Continuous Glucose Monitoring (CGM) devices, and will be sharing device readings with the provider?	Y N	
	[Note: Documentation must be submitted.]		
	[If no, then no further questions.]		
7.	Is this request for a formulary Dexcom or Freestyle Libre product?	Y N	
	[If no, then skip to question 11.]		
8.	Does the request include a quantity that exceeds the Plan limit? (Plan Quantity Limits: Dexcom G6 Receiver: 1 receiver/12 months; Dexcom G6 Sensor: 3 boxes/30 days; Dexcom G6 Transmitter: 1 transmitter/90 days; Dexcom G7 Receiver: 1 receiver/12 months; Dexcom G7 Sensor: 3 boxes/30 days; Freestyle Libre 14-Day Reader: 1 reader/12 months; Freestyle Libre 14-Day Sensor: 2 boxes/28 days; Freestyle Libre 2 Reader: 1 reader/12 months; Freestyle Libre 2 Sensor: 2 boxes/28 days; Freestyle Libre 3 Reader: 1 reader/12 months; Freestyle Libre 3 Sensor: 2 boxes/28 days)	Y N	
	[If no, then no further questions.]		
9.	Does the patient require a quantity limit exception because of a need for replacement due to lost, stolen, or damaged product?	Y N	
	[Note: Documentation must be submitted.]		
	[If yes, then no further questions.]		
10.	Does the patient require a quantity limit exception because	Y N	

of a need for an early vacation supply?		
[Note: Documentation must be submitted]		
[No further questions.]		
11. Is this request for a non-formulary Continuous Glucose Monitoring (CGM) product?	Y N	
[If no, then no further questions.]		
12. Has clinical rationale been provided indicating why the patient is unable to use the formulary Continuous Glucose Monitoring (CGM) products, and how the non-formulary product is medically necessary?	Y N	
[Note: Documentation must be submitted.]		
[If no, then no further questions.]		
13. Is the patient using an insulin pump?	Y N	
[If no, then no further questions.]		
14. Is the patient currently using an insulin pump that is paired with the non-formulary Continuous Glucose Monitoring (CGM) product being requested?	Y N	
[Note: Documentation must be submitted.]		

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date