TRICARE Prior Authorization Request Form for
Continuous Glucose Monitoring (CGM) Systems **(Dexcom G6, Dexcom G7, FreeStyle Libre 2, FreeStyle Libre 3)**

JOHNS HOPKINS
HEALTH PLANS
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to:
(410) 424 4037

To be completed by requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Initial and renewal prior authorization expires after 1 year. For renewal of therapy an initial Tricare 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 **10**
3. 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 **4**	☐ No **STOP** **Coverage not approved**
4. Is there confirmation that the patient has utilized CGM daily?	☐ Yes proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. 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 **6**	☐ No **STOP** **Coverage not approved**

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6. Does the patient continue to agree to share data with managing healthcare professional for the purposes of clinical decision making?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**
7. Does the patient have Type 2 diabetes mellitus?	☐ Yes proceed to question **8**	☐ No **Sign and date below**
8. Does the patient continue to require daily basal and prandial insulin injections?	☐ Yes **Sign and date below**	☐ No proceed to question **9**
9. Is the patient receiving insulin therapy and have a history of severe hypoglycemia episodes requiring medical intervention (grade 2 or higher)?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
10. 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 **11**	☐ No **STOP** **Coverage not approved**
11. Is the patient using basal and prandial insulin injections?	☐ Yes proceed to question **14**	☐ No proceed to question **12**
12. Is the patient using a continuous subcutaneous insulin infusion (such as insulin pump)?	☐ Yes proceed to question **14**	☐ No proceed to question **13**
13. Does the patient have diabetes and are they receiving insulin therapy and have a history of severe hypoglycemia episodes requiring medical intervention (grade 2 or higher)?	☐ 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**

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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 **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

[15 November 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: