pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

CONTINUOUS GLUCOSE MONITORING PRODUCTS

PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

Prior authorization guidelines for **Continuous Glucose Monitoring Products** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx.

☐New request ☐Renewal request	Total pages: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Product(s) requested:

☐Receiver/reader: _____ Quantity: _____

☐Transmitters: _____ Quantity: _____ per _____ days Refills: _____

☐Sensors: _____ Quantity: _____ per _____ days Refills: _____

☐Other: _____ Quantity: _____ per _____ days Refills: _____

Diagnosis *(submit documentation)*:	Dx code (*required*):

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

1. For ALL requests for a Continuous Glucose Monitoring (CGM) Product:
   - ☐The beneficiary has a diagnosis of diabetes
   - ☐The beneficiary has a diagnosis other than diabetes for which CGM is medically necessary – *submit documentation supporting the medical necessity of CGM for this beneficiary*

2. For requests for a NON-PREFERRED CGM Product:
   - ☐The beneficiary is using an insulin pump that is compatible with the requested non-preferred CGM Product
   - ☐The beneficiary has a history of trial and failure of the preferred CGM Products *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION

Prescriber Signature:	Date: