CONTINUOUS GLUCOSE MONITORING (CGM) SYSTEMS
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

Incomplete forms will be returned for additional information. The following documentation is required for preauthorization consideration. For formulary information and to download additional forms, please visit www.bcchpil.com.

PATIENT AND INSURANCE INFORMATION **Today's Date:** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
BCBS ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:

☐ Type 1 diabetes
☐ Type 2 diabetes
☐ Gestational diabetes, including up to 12 months of post-partum care
☐ Other (ICD code plus description): _____

Medication Requested: Strength:

***Your request will be reviewed for the generic equivalent unless you specify brand is required.**

Note: Brand drugs will be covered only when there has been a trial, failure, or contraindication to a generic alternative.

Dosing Schedule: Quantity per Month:

For All Requests:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
   If yes, when was treatment with the requested agent started? _____
2. Does the patient require insulin therapy? ☐ Yes ☐ No
3. Has the patient participated in or will participate in a diabetic training and/or education program regarding use of continuous glucose monitor? ☐ Yes ☐ No
4. Is the patient currently treated with the requested product? ☐ Yes ☐ No
5. Please list the medications and products the patient has **previously tried and failed for treatment of this diagnosis** (Please specify if brand name, generic, extended-release products, or OTC products)**:**

   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
   _____ Date(s): _____ _____ Date(s): _____
6. Please list all reasons for selecting the requested **agent, strength, dosing schedule, and quantity over alternatives** (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). _____
   _____
   _____
7. Please list all other products and medications the patient is **currently taking** for treatment of this diagnosis. _____
   _____
   _____

For Renewal requests:

8. Has the patient had clinical benefit with a CGM? ☐ Yes ☐ No

Please fax or mail this form to:
Blue Cross and Blue Shield of Illinois
c/o Prime Therapeutics LLC, Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, Minnesota 55121

TOLL FREE
Fax: 877.243.6930 **Phone: 800.285.9426**