CONTINUOUS GLUCOSE MONITOR (CGM)
STEP THERAPY REQUEST
PRESCRIBER FAX FORM

ONLY the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.
By submitting this form, you attest that all information provided is true and accurate.

PLEASE NOTE: Incomplete forms will be returned for additional information.
To ensure you are submitting this form correctly, you can complete and submit it directly to us online at www.covermymeds.com
For formulary information, please visit www.myprime.com

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

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):
Patient Street Address:	City, State	ZIP:	Patient Phone:
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State		ZIP

RENDERING/SERVICING PRESCRIBER INFORMATION (IF APPLICABLE)

Prescriber First Name:	Prescriber Last Name:	NPI:	Specialty:
Clinic Name:	Contact Name:	Phone:	Secure Fax:
Clinic Street Address:	City, State:		ZIP:

MEDICAL INFORMATION. PLEASE ATTACH ADDITIONAL INFORMATION AS NEEDED.

Patient diagnosis with ICD-9 Code:	ICD-10 Code:
Medication and Strength Requested:	
Dosing Schedule:	Quantity per Month:

Please list the medications the patient has previously tried and failed for the treatment of this diagnosis:

_____ Date range: _____ _____ Date range:_____
_____ Date range: _____ _____ Date range:_____
_____ Date range: _____ _____ Date range:_____

Is the patient currently treated with the requested medication? ..... ☐ Yes ☐ No

Please list all reasons for selecting the requested medication, 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). _____

_____

_____

Please select which type of therapy the patient requires and answer all corresponding questions:

☐ **Short-term monitoring of glucose levels in interstitial fluid**

Is the patient insulin dependent? ..... ☐ Yes ☐ No

If no: Is the patient insulin dependent prior to insulin pump initiation to determine basal insulin levels?..... ☐ Yes ☐ No

Please continue to the next page.

Patient First Name:	Patient Last Name:	MI:	DOB (mm/dd/yyyy):

☐ **Continuous long-term monitoring of glucose levels in interstitial fluid, including real-time monitoring, as a technique of diabetic monitoring**

Is the patient capable of using the devices safely (either independently or with the assistance of a caregiver)?..... ☐ Yes ☐ No

For adults, does the patient have diabetes? ..... ☐ Yes ☐ No

If yes, does the patient on one of the following (select one)? ..... ☐ Yes ☐ No

- ☐ Multiple daily injections
- ☐ Continuous subcutaneous insulin injections
- ☐ Basal insulin

For youth, does the patient have type 1 diabetes or type 2 diabetes (select one)?. ..... ☐ Yes ☐ No

- ☐ Type 1 diabetes
- ☐ Type 2 diabetes

If yes, is the patient on one of the following (select one)?..... ☐ Yes ☐ No

- ☐ Multiple daily injections
- ☐ Continuous subcutaneous insulin injections

☐ Other (Please specify): _____

Please indicate:

- ☐ Date of service (if applicable): (mm/dd/yyyy): _____
- ☐ Start of treatment: Start date (mm/dd/yyyy): _____
- ☐ Continuation of therapy: Date of last treatment (mm/dd/yyyy): _____

What is the priority level of this request?

- ☐ Standard
- ☐ Urgent (NOTE: Urgent is defined as when the prescriber believes that waiting for a standard review could seriously harm the patient's life, health, or ability to regain maximum function.)

If yes: Please specify: _____

_____

Please fax or mail this form to:
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2900 Ames Crossing Road
Eagan, MN 55121

TOLL FREE
FAX: 855.212.8110 PHONE: 888.271.3183