



**NC Medicaid  
Pharmacy Prior Approval Request for  
Continuous Glucose Monitors**

**Beneficiary Information**

1. Beneficiary Last Name: \_\_\_\_\_ 2. First Name: \_\_\_\_\_  
3. Beneficiary ID #: \_\_\_\_\_ 4. Beneficiary Date of Birth: \_\_\_\_\_ 5. Beneficiary Gender: \_\_\_\_\_

**Prescriber Information**

6. Prescribing Provider NPI #: \_\_\_\_\_  
7. Requester Contact Information - Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Ext. \_\_\_\_\_

**Drug Information**

8. Transmitter/ Sensor Name:  Dexcom G6  Dexcom G7  FreeStyle Libre 14 day  FreeStyle Libre 2  FreeStyle Libre 3  
9. Quantity for Transmitter (G6) \_\_\_\_\_ (Max 1) 10. Quantity for Dexcom (G6/G7) Sensor \_\_\_\_\_ (Max 3)  
11. Quantity for Reader(Libre 14 day/Libre 2 and 3) \_\_\_\_\_ (Max 1) 12. Quantity for Sensors (Libre 14 day / Libre 2 and Libre 3) \_\_\_\_\_ (Max 2)  
13. Length of therapy (in days) for Dexcom G6 Transmitter, Dexcom G6 and G7 Sensor, Libre 14 day /Libre 2 and 3 Reader and Sensors and Libre 3 Sensors:  up to 30 days  60 days  90 days  120 days  180 days  365 days  Other: \_\_\_\_\_  
\*\*Max Length of Therapy for Initial Authorization is 180 days\*\*  
**For Dexcom G6 and G7 only:**  
14. Does the beneficiary have a smart device (phone/computer/tablet) to receive transmissions from the Dexcom G6 or G7?  
 Yes  No (Answering "NO" indicates that the beneficiary needs the Dexcom Receiver)

**Clinical Information**

**For initial therapy, please answer questions 1-9, (max 6 months authorization):**  
1. Does the beneficiary have a diagnosis of insulin-dependent diabetes?  Yes  No  
2. Is the beneficiary and/or caregiver(s) willing and able to use the therapeutic CGM system as prescribed?  Yes  No  
3. Has the beneficiary had a face-to-face encounter with the treating practitioner to evaluate the beneficiary's glycemic control and determine that criteria one and two(1 and 2) above have been met, within six months of the initial authorization?  Yes  No  
4. Does the beneficiary use an external insulin pump?  Yes  No  
5. Does the beneficiary have a diagnosis of gestational diabetes?  Yes  No  
6. For coverage of Dexcom G6 or G7; is the beneficiary age 2 years or older?  Yes  No  
7. For coverage of FreeStyle Libre 14 day is the beneficiary age 18 years or older?  Yes  No  
8. For coverage of FreeStyle Libre 2 and Libre 3 is the beneficiary age 4 years or older?  Yes  No  
9. For coverage of FreeStyle Libre 14 day, has the beneficiary tried using, Dexcom G6 or G7, or Freestyle Libre 2 or 3?  Yes  No  
If no, is there a clinical reason Dexcom G6, Dexcom G7, or Freestyle Libre 2 or 3 could not be used?  Yes  No  
If yes, explain \_\_\_\_\_  
**For first reauthorization, please answer questions 10-12, (max 12-month authorization) DOCUMENTATION REQUIRED:**  
10. Has the beneficiary been using the CGM as prescribed?  Yes  No  
11. Has the beneficiary been able to improve glycemic control?  Yes  No  
12. Does the beneficiary continue to use as external insulin pump?  Yes  No  
**For Subsequent reauthorizations please answer questions 13-16, (max 12-month authorization) DOCUMENTATION REQUIRED**  
13. Has the beneficiary had a face-to-face encounter with the ordering practitioner to evaluate the efficacy of the CGM system no more than three (3) months prior to submission of this reauthorization request?  Yes  No  
14. Has the beneficiary been using the CGM system as prescribed?  Yes  No  
15. Has the beneficiary been able to maintain or further improve glycemic control?  Yes  No  
16. Does the beneficiary continue to use an external insulin pump?  Yes  No

Signature of Prescriber: \_\_\_\_\_ Date: \_\_\_\_\_  
**(Prescriber Signature Mandatory)**

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.