

Prior Authorization Form



NOTE: Refer to the Provider Manual for additional services requiring **Prior Authorization**

Fax Form To: Grand Rapids – 616 942-0024 Holland – 616 392-7626 ASO – 616 395-4090 Traverse City – 231 932-9505 Farmington Hills – 888 647-6152

Continuous Glucose Monitoring System

Member

Last Name: _____ First Name: _____

ID #: _____ DOB: _____

Plan/Product Type: : EPO HMO POS SF-POS PPO Medicaid Medicare

Primary Care Physician: _____ PCP Phone: _____ PCP Fax: _____

Has PCP been notified of request? Yes No

Requested By:

Provider Name: _____ Phone: _____ Fax: _____

Address: _____ Contact Name: _____

_____ Date of Request: _____

Criteria for approval of CGMS (includes purchase of the receiver/transmitter unit and sensors)

Continuous glucose monitoring devices and real-time glucose sensors are covered when deemed appropriate by the ordering physician for any of the following (check applicable box):

- HbA1C > 7.0
- documented hypoglycemic unawareness
- documented hypoglycemic seizures
- documented nocturnal hypoglycemia
- use during pregnancy at the discretion of the maternal medicine specialist. Use after pregnancy requires re-authorization.

Other limitations/considerations:

1. The prescribing provider must agree to review patient downloads via any telemonitoring transmission, fax or mailed data.
2. Telephonic patient consultations are reimbursable services.
3. Receiver purchase is limited to **one** every 3 years.

*****ALL FIELDS MUST BE COMPLETE AND LEGIBLE FOR PRIOR AUTHORIZATION REVIEW*****