

CONTINUOUS GLUCOSE MONITOR PRIOR AUTHORIZATION REQUEST PRESCRIBER FAX FORM

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

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member 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 - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently being treated with the requested product? Yes No
 If yes, has the patient been treated with the requested agent within the past 90 days (starting on samples is not approvable)? Yes No
 If yes, is the patient at risk if therapy is changed? Yes No
 If yes, please specify risk: _____

2. Does the patient have a medication history of use in the past 90 days of ONE diabetic agent [i.e., agents containing metformin, agents containing insulin, agents containing DPP-4 inhibitors, agents containing SGLT2 inhibitors, sulfonylureas, dopamine receptor agonists-ergot derivatives (e.g., bromocriptine), d-phenylalanine derivatives, meglitinide analogues, alpha-glucosidase inhibitors, thiazolidinediones, sulfonylurea-thiazolidinedione combinations]? **Please note, chart notes are required.** Yes No

3. Does the patient have a disability that requires use of a continuous blood glucose monitor? Yes No

4. Does the patient have recurring episodes of hypoglycemia? Yes No

5. Is the patient's age within the manufacturer recommendations for the requested indication for the requested product? Yes No
 If yes, is there information in support of using the requested product for the patient's age? Yes No
 If yes, please provide supporting information: _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
<p>6. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____</p> <p>_____</p> <p>_____</p>			
<p>Please fax or mail this form to: Prime Therapeutics LLC Clinical Review Department 2900 Ames Crossing Road Suite 200 Eagan, MN 55121</p> <p>TOLL FREE</p>		<p>CONFIDENTIALITY NOTICE: This communication is intended only for the use of the individual entity to which it is addressed, and may contain information that is privileged or confidential. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited. If you have received this communication in error, please return the original message to Prime Therapeutics via U.S. Mail. Thank you for your cooperation.</p>	
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