Jefferson Health Plans

PRIOR AUTHORIZATION REQUEST FORM
Individual and Family Plans

Continuous Glucose Monitors (CGMs)

Fax back to: (833) 605-4407
Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is this a request for reauthorization? If YES, go to 2. If NO, go to 4.

☐ Yes ☐ No

Q2. There is documentation of a positive clinical response (ie, improvement in glycemic control, reduction or improvement in hypoglycemic events).

☐ Yes ☐ No

Q3. The member is being evaluated by the prescriber for adherence to their CGM regimen and diabetes treatment plan and confirms that member is benefiting from CGM therapy.

☐ Yes ☐ No

Q4. The patient has an established diagnosis of diabetes mellitus.

☐ Yes ☐ No

Q5. The requested product is prescribed in accordance with its FDA indications for use.

☐ Yes ☐ No

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Q6. The requested product is age-appropriate according to FDA-approved package labeling, national compendia, or peer-reviewed medical literature.

☐ Yes ☐ No

Q7. The member is adherent to current diabetes treatment plan and participates in ongoing diabetes education and support.

☐ Yes ☐ No

Q8. The member is treated with insulin.

☐ Yes ☐ No

Q9. The member is non-insulin treated and experiences significant hypoglycemia with at least one of the following:

☐ 1. Recurrent level 2 hypoglycemic events (glucose less than 54 mg/dL (3 mmol/L)) that persist despite multiple attempts to adjust medication(s) and/or modify the diabetes treatment plan

☐ 2. History of one level 3 hypoglycemic event (glucose less than 54 mg/dL (3 mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia

Q10. Is the request for a preferred formulary product?

☐ Yes ☐ No

Q11. There is documentation of inadequate response, intolerance, or contraindication to all formulary CGMs indicated for the patient's diagnosis.

☐ Yes ☐ No

Q12. Additional Information:

Prescriber Signature

Date

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