Part B Continuous Glucose Monitor (CGM) Prior Authorization Request Form

Florida Blue
Your Health Solutions Partner | MEDICARE

Fax: 1-904-357-6699
Phone: 1-904-357-3900 Ext. 89277

PLEASE:

- Complete this form, and fax or call the number listed.
- Note any information left blank or illegible may delay the review process.
- Use one form per prior authorization request.

REQUEST TYPE:

☐ Standard Review (72 hours)

☐ Expedited Review (24 hours) By checking this box I certify that applying the 72-hour standard review timeframe might seriously jeopardize the life or health of the member or the member's ability to regain maximum function.

I. MEMBER INFORMATION		**II. PRESCRIBER INFORMATION**	
Name:		Name:	
ID Number:		Specialty:	
Date of Birth:		NPI:	
Address:		Office Contact Name:	
Phone Number:		Phone Number:	
		Fax Number:	

III. CGM REQUESTED		**IV. CLINICAL INFORMATION**
CGM brand/model/NDC:	Brand/model:	Diagnosis (description, ICD-10 and Z codes):
	NDC:	
Requested CGM product(s):	☐ CGM receiver (device) and supplies needed OR ☐ CGM supplies only	Is the member currently on insulin? ☐ Yes ☐ No
Is member currently using CGM?	☐ Yes ☐ No	Clinical rationale for CGM:
How many units does the patient require PER MONTH? (If the request is for more than the standard monthly supply, please provide quantity requested and directions for use.)		Within six (6) months prior to ordering the CGM, has the treating practitioner had an in-person or Medicare-approved telehealth visit with the member to evaluate their diabetes control and determined that CGM criteria are met? ☐ Yes ☐ No
Start date of therapy:		Date of last visit with treating practitioner:
If CONTINUING therapy, include Florida Blue prior approval.	Prior Florida Blue approval Cert #:	**Note: Even if member is picking up their CGM at a pharmacy, this will be processed under Part B (medical/DME) benefit.**

Note: Prescriber needs to submit a new prescription for the requested CGM to a local in-network or participating home delivery pharmacy, which will be supplied through the member's PART B Benefit, if request is approved by Florida Blue.

PRESCRIBER NAME	**SIGNATURE**	**DATE & TIME**

VII. PERTINENT CLINICAL INFORMATION

Clinical information is required to make a determination. Missing information and slow responses will delay completion of this request. PLEASE ATTACH pertinent medical history, progress notes, laboratory and diagnostic test results that may support approval. Additional notes can be included in the space below.