



## CONTINUOUS GLUCOSE MONITORING PRODUCTS

### PRIOR AUTHORIZATION FORM (form effective 1/5/2026)

Prior authorization guidelines for **Continuous Glucose Monitoring Products** and **Quantity Limits/Daily Dose Limits** are available on the DHS Pharmacy Services website at <https://www.dhs.pa.gov/providers/Pharmacy-Services/Pages/default.aspx>.

<input type="checkbox"/> New request	<input type="checkbox"/> Renewal request	Total pages: _____	Prescriber name:
Name of office contact:		Specialty:	
Contact's phone number:		NPI:	State license #:
LTC facility contact/phone:		Street address:	
Beneficiary name:		City/state/zip:	
Beneficiary ID#:	DOB:	Phone:	Fax:

### CLINICAL INFORMATION

Product(s) requested:	
<input type="checkbox"/> Receiver/reader: _____	Quantity: _____
<input type="checkbox"/> Transmitters: _____	Quantity: _____ per _____ days    Refills: _____
<input type="checkbox"/> Sensors: _____	Quantity: _____ per _____ days    Refills: _____
<input type="checkbox"/> Other: _____	Quantity: _____ per _____ days    Refills: _____
Diagnosis ( <i>submit documentation</i> ):	Dx code ( <i>required</i> ):

**Complete all sections that apply to the beneficiary and this request.**  
**Check all that apply and submit documentation for each item.**

<p><b>1. For ALL requests for a Continuous Glucose Monitoring (CGM) Product:</b></p> <p><input type="checkbox"/> The beneficiary has a diagnosis of diabetes</p> <p><input type="checkbox"/> The beneficiary has a diagnosis other than diabetes for which CGM is medically necessary – <i>submit documentation supporting the medical necessity of CGM for this beneficiary</i></p>
<p><b>2. For requests for a NON-PREFERRED CGM Product:</b></p> <p><input type="checkbox"/> The beneficiary is using an insulin delivery device that is compatible with the requested non-preferred CGM Product</p> <p><input type="checkbox"/> The beneficiary has a history of trial and failure of the preferred CGM Products (<i>Refer to <a href="https://papdl.com/preferred-drug-list">https://papdl.com/preferred-drug-list</a> for a list of preferred and non-preferred drugs in this class.</i>)</p>

**PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION**

Prescriber Signature:	Date:
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