GHP Family Pharmacy Customer Service
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Geisinger

CONTINUOUS GLUCOSE MONITORING PRODUCTS

PRIOR AUTHORIZATION FORM *(form effective 1/8/2024)*

Prior authorization guidelines for **Continuous Glucose Monitoring Products** and **Quantity Limits/Daily Dose Limits** are available on Geisinger Health Plan's website at https://healthplan.geisinger.org/pharmacy/pharmacy.aspx?strip=true&style=OneGeisinger

☐New request ☐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:

☐Receiver/reader: _____ Quantity: _____

☐Transmitters: _____ Quantity: _____ per _____ days Refills: _____

☐Sensors: _____ Quantity: _____ per _____ days Refills: _____

☐Other: _____ Quantity: _____ per _____ days Refills: _____

Diagnosis *(submit documentation)*:	Dx code (*required*):

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

1. **For ALL requests for a Continuous Glucose Monitoring (CGM) Product:**
   - ☐The beneficiary has a diagnosis of diabetes
   - ☐The beneficiary has a diagnosis other than diabetes for which CGM is medically necessary – *submit documentation supporting the medical necessity of CGM for this beneficiary*

2. **For requests for a NON-PREFERRED CGM Product:**
   - ☐The beneficiary is using an insulin pump that is compatible with the requested non-preferred CGM Product
   - ☐The beneficiary has a history of trial and failure of the preferred CGM Products *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

Please submit to PromptPA https://ghp.promptpa.com OR fax to Geisinger Health Plan at 570-271-5610 the completed form with required clinical documentation.

Prescriber Signature:	**Date**: