Trillium Health Resources
Pharmacy Prior Approval Request for

Trillium HEALTH RESOURCES
Transforming Lives. Building Community Well-Being.

Continuous Glucose Monitors

Member Information

1. Last Name: _____ 2. First Name: _____
3. Trillium ID #: _____ 4. Date of Birth: _____ 5. Gender: _____

Prescriber Information

1. Prescriber Name: _____ 2. NPI #: _____
3. Requestor Name (Nurse/Office Staff): _____
4. Mailing Address: _____ City: _____ State: ____ Zip: _____
3. Phone #: _____ Ext. _____ Fax #: _____

Drug Information

1. Transmitter/ Sensor Name: ☐ Dexcom G6 ☐ Dexcom G7 ☐ FreeStyle Libre 14 day ☐ FreeStyle Libre 2 ☐ FreeStyle Libre 3
2. Quantity for Transmitter (G6) _____ (Max 1) 3. Quantity for Dexcom (G6/G7) Sensor _____ (Max 3)
4. Quantity for Reader (Libre 14 day/Libre 2) _____ (Max 1) 5. Quantity for Sensors (Libre 14 day / Libre 2 and Libre 3) (Max 2)
6. Length of therapy (in days) for Dexcom G6 Transmitter, G6 and G7 Sensor, Libre 14 day /Libre 2 Reader and Libre 3 Sensors:
   ☐ up to 30 days ☐ 60 days ☐ 90 days ☐ 120 days ☐ 180 days ☐ 365 days ☐ Other: _____

****Max Length of Therapy for Initial Authorization is 180 days****

For Dexcom G6 and G7 only:

7. Does the member have a smart device (phone/computer/tablet) to receive transmissions from the Dexcom G6 or G7?
   ☐ **Yes** ☐ **No** (Answering "NO" indicates that the beneficiary needs the **Dexcom Receiver**)

Clinical Information

For initial therapy, please answer questions 1-9, (max 6 months authorization):

1. Does the member have a diagnosis of insulin-dependent diabetes? ☐ **Yes** ☐ **No**
2. Is the member and/or caregiver(s) willing and able to use the therapeutic CGM system as prescribed? ☐ **Yes** ☐ **No**
3. Has the member had a face-to-face encounter with the treating practitioner to evaluate the beneficiary's glycemic control and determine that criteria one through five (1-5) above have been met, within six months of the initial authorization? ☐ **Yes** ☐ **No**
4. Does the member use an external insulin pump? ☐ **Yes** ☐ **No**
5. Does the member have a diagnosis of gestational diabetes? ☐ **Yes** ☐ **No**
6. For coverage of Dexcom G6 or G7; is the member age 2 years or older? ☐ **Yes** ☐ **No**
7. For coverage of FreeStyle Libre 14 day is the member age 18 years or older? ☐ **Yes** ☐ **No**
8. For coverage of FreeStyle Libre 2 and Libre 3 is the member age 4 years or older? ☐ **Yes** ☐ **No**
9. For coverage of FreeStyle Libre 14 day, has the member tried using Dexcom G6 or G7, or Freestyle Libre 2 or 3? ☐ **Yes** ☐ **No**
   a. If '**NO**', is there a clinical reason Dexcom G6, Dexcom G7, or Freestyle Libre 2 or 3 could not be used? ☐ **Yes** ☐ **No**
   b. **If 'YES'**, explain _____

For first reauthorization, please answer questions 10-12, (max 12-month authorization) DOCUMENTATION REQUIRED:

10. Has the member been using the CGM as prescribed? ☐ **Yes** ☐ **No**
11. Has the member been able to improve glycemic control? ☐ **Yes** ☐ **No**
12. Does the member continue to use as external insulin pump? ☐ **Yes** ☐ **No**

For subsequent reauthorizations please answer questions 13-16, (max 12-month authorization) DOCUMENTATION REQUIRED:

13. Has the member had a face-to-face encounter with the ordering practitioner to evaluate the efficacy of the CGM system no more than three (3) months prior to submission of this reauthorization request? ☐ **Yes** ☐ **No**
14. Has the member been using the CGM system as prescribed? ☐ **Yes** ☐ **No**
15. Has the member been able to maintain or further improve glycemic control? ☐ **Yes** ☐ **No**
16. Does the member continue to use an external insulin pump? ☐ **Yes** ☐ **No**

Signature of Prescriber: _____ Date: _____

(Prescriber Signature Mandatory)

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.