



**PRIOR AUTHORIZATION REQUEST:
Real-Time Continuous Glucose Monitor (RT-CGM)**

Please fax form and required documents to Express Scripts: 1-877-251-5896

MEMBER INFORMATION	
Name:	Amida Care ID #:
Phone #:	Date of Birth:
PRESCRIBER INFORMATION	
Name/Title:	NPI:
Office Phone #:	Office Fax #:
Address:	
Contact Person:	
MEDICATION REQUEST	
Continuous Glucose Monitor Product Requested:	
Is this for the initial request or subsequent request?	<input type="checkbox"/> Initial <input type="checkbox"/> Subsequent
CLINICAL CRITERIA	
<i>***Please answer ALL of the following questions and provide most recent and relevant laboratory/physical exam results***</i>	
1. What is the patient's diagnosis (i.e. type 1 diabetes, type 2 diabetes, gestational diabetes)? Please include ICD-10 code.	
2. Is the patient under the care of an endocrinologist, or a provider with experience in diabetes treatment, who orders the device?	
3. Is the patient compliant with regular visits to review RT-CGM data with their provider?	
4. Is the patient on an insulin treatment plan that requires frequent adjustment of insulin dosing or an insulin pump?	
5. Is the patient able to, or has a caregiver who is able to, hear and view RT-CGM alerts and respond appropriately?	
Please attach any additional supporting documentation and notes relevant to the diagnosis: (Failure to provide clinical documentation or supporting rationale may result in a delay or denial in your request):	
<p><i>Please call 646-757-7979, M-F, 9:00AM – 6:00PM with questions or additional information. You may also provide us with your contact information and the best time to reach you in the space at the top of this document.</i></p>	
_____	____/____/____
Prescriber or Authorized Signature	Date