NYRx the Medicaid Pharmacy Program

Continuous Glucose Monitor (CGM) Prior Authorization Worksheet

Fax Number: 1-800-268-2990

Processing may be delayed if information submitted is illegible or incomplete. If your fax includes the standardized fax form, only the **Member Name, DOB, ID,** and **Clinical Criteria** need to be completed and faxed as an attachment to process your request.

ENROLLEE INFORMATION

Enrollee Last Name: ______________________________

Enrollee First Name: ______________________________

Date of Birth: ______________________________

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): ______________________________

Enrollee Street Address: ______________________________

City: ______________________________ State: _______ Zip: ______________

PRESCRIBER INFORMATION

Prescriber Last Name: ______________________________

Prescriber First Name: ______________________________

Prescriber NPI Number: ______________________________

Board-Certified Specialty: ______________________________

Prescriber Street Address: ______________________________

City: ______________________________ State: _______ Zip: ______________

Prescriber Phone: ______________________________ Prescriber Fax: ______________________________

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Enrollee's Full Name: ____________________

REQUESTED DRUG – CGM INFORMATION

Drug Name: ____________________

Select the requested drug below:

- ☐ Freestyle Libre 14 Day Reader
- ☐ Freestyle Libre 14 Day Sensor
- ☐ Freestyle Libre 2 Sensor
- ☐ Freestyle Libre 2 Reader
- ☐ Freestyle Libre 3 Sensor
- ☐ Dexcom G6 Receiver
- ☐ Dexcom G6 Sensor
- ☐ Dexcom G6 Transmitter
- ☐ Dexcom G7 Receiver
- ☐ Dexcom G7 Sensor

Quantity: ____________________

Refills: ____________________

Directions: ____________________

Is the patient established on this product?
☐ Yes ☐ No

If **Yes**, date therapy was initiated: ____________________

CLINICAL CRITERIA – DIAGNOSIS

1. What is the patient's diagnosis?
   - ☐ Gestational Diabetes (Stop here if patient has gestational diabetes.)
   - ☐ Diabetes Mellitus Type 1
   - ☐ Diabetes Mellitus Type 2
   - ☐ Other: ____________________
2. Does the patient need to administer insulin or is the patient on an insulin pump?
   ☐ Yes ☐ No

   If **No**, provide rationale:

Enrollee's Full Name: ____________________

3. Has the patient received adequate education regarding device calibration and monitor alerts?

   ☐ Yes ☐ No

4. Is there a scheduled follow-up visit with the patient to assess the regimen within the next 6 months?

   ☐ Yes ☐ No

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

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Prior Authorization Call Line: 1-877-309-9493

Billing Questions: 1-800-343-9000. For clinical questions or Clinical Drug Review Program questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.

For the Preferred Diabetic Supply list, please visit:
https://newyork.fhsc.com/downloads/providers/NYRx_PDSP_preferred_supply_list.pdf