

## PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

## **Continuous Glucose Monitors (CGMs)**

Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

Patient Name:	Prescriber Name:
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	Specialty/facility name (if applicable):
REQUEST FOR EXPEDITED REVIEW: By checking this the enrollee or the enrollee's ability to regain maximum Drug Name:	box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health o function.
Strength:	
Directions / SIG:	
	istory including labs and information for this member that may support approval.
Q1. Does the patient have an es	tablished diagnosis of Diabetes Type 1 or Type 2?
☐ Yes	□ No
Q2. Is the patient being treated subcutaneous insulin infusion (C	vith at least 3 daily injections of insulin or using a continuous SII) pump?
☐ Yes	□ No
Q3. Does the patient's insulin tre (self-blood glucose monitoring)	atment regimen require frequent adjustments based on SBGM r CGM testing results?
☐ Yes	□ No
Q4. Additional Information:	
Prescriber Signature	Date

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PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

	Patient Name:	Prescriber Name:
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