MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

# PRIOR AUTHORIZATION FOR CONTINUOUS GLUCOSE MONITORING DEVICE AND/OR TUBELESS INSULIN PUMP

RETURN TO: ATTN: DRUG PRIOR AUTHORIZAITON
MO HEALTHNET DIVISION
PO BOX 4900
JEFFERSON CITY, MO 65102-4900

**PLEASE PRINT OR TYPE. ALL INFORMATION MUST BE SUPPLIED OR THE REQUEST WILL NOT BE PROCESSED.**
PHONE: (800) 392-8030 FAX: (573) 636-6470

☐ CGM (Dexcom G6®) ☐ Tubeless Insulin Pump (Omnipod®/Omnipod Dash®)

| ☐ Initial Request ☐ Renewal Request | PARTICIPANT MO HEALTHNET NUMBER |
|---|---|
| PARTICIPANT NAME | DATE OF BIRTH |

DIAGNOSIS INCLUDING ICD-10 CODE (Must provide diagnosis consistent with medically accepted use)

| DATE DIAGNOSIS ESTABLISHED | NDC (NATIONAL DRUG CODE) |
|---|---|

Is the patient currently using the requested product? ☐ Yes ☐ No

If yes, date product was first used: ________________________

If this is a NEW request for a CGM, please provide:
- Product currently used to test blood glucose
- Length of time the patient has been using the product
- Current testing schedule

If this is a NEW request for a Tubeless Insulin Pump, please provide:
- Product currently used to administer insulin
- Type of insulin
- Average amount of insulin administered daily

List patient's current insulin regimen, including dose, administration schedule, and length of time patient has used insulin.

Does the participant have any of the following? Please check all that apply.

☐ Patient is unable to consistently and reliably identify hypoglycemic events (e.g. hypoglycemic unawareness).

☐ Patient has a Hemoglobin A1c > 7.0

☐ Patient has a history of hypoglycemia (blood glucose <65 mg/dl for children under 8 years old and <55 for all other clients), including recurrent hypoglycemia or nocturnal hypoglycemia.

☐ Patient has a recent history (within the last six months) of hospitalization or emergency room visits for conditions attributed to a hypoglycemic or hyperglycemia event. Please note that an ER visit or admission that is associated with the initial diagnosis (Type 1) does not meet criteria and should not be reported here.

Date of hospitalization: ________________________

☐ Patient has coexistent morbidity that poses an unusual challenge with concomitant hypoglycemia or hyperglycemia (e.g. uncontrolled epilepsy.)

List patient's comorbid condition(s):

______________________________________________________________________

**Tubeless insulin pumps will be denied if patient history shows a paid claim for a tubed insulin pump in the past 2 years.**

**ATTACH ANOTHER SHEET IF ADDITIONAL DOCUMENTATION IS REQUIRED. FOR SPECIFIC REQUIREMENTS, YOU MAY CALL 1-800-392-8030.**

| PRESCRIBER NAME AND SPECIALTY | | PRESCRIBER PROVIDER NPI |
|---|---|---|
| PRESCRIBER TELEPHONE NUMBER | PRESCRIBER FAX NUMBER | PRESCRIBER OTHER CONTACT INFO: |
| NAME, TITLE AND CREDENTIALS OF PERSON COMPLETING FORM | | |
| TELEPHONE NUMBER OF PERSON COMPLETING FORM | FAX NUMBER OF PERSON COMPLETING FORM | OTHER CONTACT INFO OF PERSON COMPLETING FORM: |
| SIGNATURE OF PERSON COMPLETING FORM | | DATE |