MISSOURI DEPARTMENT OF SOCIAL SERVICES
MO HEALTHNET DIVISION

CONTINUOUS GLUCOSE MONITORING DEVICE PRIOR AUTHORIZATION

Save Print Reset

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

☐ 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	REQUESTED PRODUCT

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

If yes, date product was first used: _____

If no, list the product currently used to test blood glucose, including testing schedule and length of use.

List patients current insulin regimen, including dose, schedule, and length of product use.

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 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):

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

REQUESTING PHYSICIAN OR ADVANCED PRACTICE NURSE NAME AND TITLE	TELEPHONE NUMBER	FAX NUMBER
ADDRESS	PROVIDER SPECIALTY	PROVIDER NPI
PHYSICIAN'S OR APN'S SIGNATURE (ORIGINAL) AND TITLE		DATE SIGNED