Diabetic Supplies Request Form

CGM & SMBG

Ver. 1.0

Phone: 844-464-6554
Fax: 909-494-5582

PATIENT INFORMATION		PATIENT'S MOST RECENT (REQUIRED)	
Name: _____		A1C: _____%	Date: _____
DOB: _____	Phone: _____	Date of Last Visit: _____	
Address: _____		Diabetes Type: _____	
Insurance Name: _____	ID: _____	Diabetes ICD-10 Code: _____	
☐ **Insulin Treatment (name and frequency):** _____			

PRESCRIBED ORDER INFORMATION	
☐	**Continuous Glucose Monitoring (CGM) System and Supplies, Directions and Quantity** ✓ Dexcom G6 Receiver* (#1): if needed, use receiver to scan transmitter for blood glucose readings ✓ Dexcom G6 Transmitter* (#1): use one transmitter every 90 days with the sensor ✓ Dexcom G6 Sensor Kit* (3 pack): apply one sensor every 10 days ✓ Alcohol Pads (1 box): use alcohol pad to clean site prior to applying sensor **Refills will be automatically set for 1 year unless otherwise specified** *Subject to brand change upon patient or provider request
☐	**(Optional) SMBG only if required while using CGM** ✓ Glucometer (#1) ✓ Lancing Device (#1) ✓ BG Test Strips (#50) ✓ Lancets (#100) ✓ Ketone Strips (#10)* (sig: Check every 4-6 hours when needed (refer to Gojji Ketone handout)) ✓ Ketone Control Solution (#1) ✓ BG Control Solution (#1) **Sig: Test as needed while using CGM, #50 (per 100 day supply)** **Refills will be automatically set for 1 year unless otherwise specified**

Prior authorization criteria for Continuous Glucose Monitoring CGM under Medi-Cal Rx, a beneficiary must meet ALL of the following criteria. Please complete the following, including the free form fields and checkboxes:

- ☐ Is under the immediate and ongoing care of, and the CGM is ordered by, an endocrinologist or a healthcare practitioner with experience in diabetes management and continuous subcutaneous insulin infusion therapy
- ☐ Is within the manufacturer's recommendations for appropriate age range (Dexcom: > 2 years old)
- ☐ Type 1 insulin-dependent diabetes mellitus diagnosis, appropriate **ICD-10 code (REQUIRED) _____**
- ☐ Is on an insulin treatment plan that requires multiple (three or more) daily injections of insulin or a continuous subcutaneous insulin infusion (CSII) pump

†Form not valid for use by providers prescribing in the state of Arizona to comply with state regulations. Please contact us for more information.

- ☐ Is on an insulin treatment regimen that requires frequent adjustments of insulin dosing on the basis of self-monitoring blood glucose testing an average of three (3) times or more per day or continuous glucose monitoring testing results
- ☐ Has completed a comprehensive diabetes education program or diabetes prevention program within the last twelve (12) months
- ☐ The beneficiary and/or caregiver demonstrates the ability to understand and appropriately respond to information displayed on a CGM receiver (monitor)
- ☐ The beneficiary and/or caregiver demonstrates a high level of motivation to achieve tighter glucose control and competency to accurately use the CGM system and comply with recommended use and as instructed in the manufacturers' current labeling
- ☐ Has been seen and evaluated by an endocrinologist or a healthcare practitioner with experience in diabetes management and continuous subcutaneous insulin infusion therapy at least every six (6) months, either in person or virtually through video or telephone conferencing, to evaluate their diabetes control and determines that criteria (2-8) above have been met and documented **(INCLUDE LAST SEEN DATE IN THE PATIENT'S MOST RECENT ABOVE)**
  - ☐ **FOR REAUTHORIZATION ONLY:**
    Has been seen and evaluated no more than three (3) months prior to submission of the reauthorization request. Visit summaries must accompany each request and should include a written narrative by the prescriber documenting that the beneficiary is doing the following: − Using the device as prescribed − Documenting the number of days the CGM is worn − Achieving or maintaining clinical targets where the prescriber defines the clinical targets and includes A1C values. Additional metrics may be included specific to the device such as Time in Range, mean glucose, or other analytics if readily retrievable **(INCLUDE LAST SEEN DATE IN THE PATIENT'S MOST RECENT ABOVE)**

- ☐ The beneficiary and/or caregiver agrees that the beneficiary will wear (new start) or has worn (continuing) the CGM at least five (5) days per week of use or twenty (20) days of use per month

Note: To avoid wastage, Gojji® Disease Management Program ensures appropriate use of testing supplies by providing individualized testing reminders based on patients' conditions. Gojji® never sends any supplies automatically and sends adequate supplies based on patients' real-time utilization and conditions only.

PRESCRIBER INFORMATION

Name: _____

NPI: _____

Phone: _____ Prescriber Signature: _____

Fax: _____ Today's Date: _____

Clinic Address: _____

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