**MOLINA HEALTHCARE**
**Service Authorization (SA) Form**
**Continuous Glucose Monitoring (CGM)**

If the following information is not complete, correct, or legible, the SA process can be delayed.
Please use one form per member.

## MEMBER INFORMATION

**Member's Last Name:**

**Member's First Name:**

**MOLINA ID Number:**

**Date of Birth:** – –

**Gender:** ☐ Male ☐ Female

## PRESCRIBER INFORMATION

**Prescriber's Last Name:**

**Prescriber's First Name:**

**NPI Number:**

**Specialty:** ____________________

**Phone Number:** – –

**Fax Number:** – –

**Street Address:**

**City:**

**State:**

**Zip Code:**

## DEVICE INFORMATION

**Device Name:** ____________________

**Quantity:** ____________________

**Directions for Use:** ____________________

**Diagnosis:** ____________________

*(Form continued on next page.)*



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**Member's Last Name:** | | | | | | | | | | | |

**Member's First Name:** | | | | | | | | | | | |

## DEVICE INFORMATION *(Continued)*

***For Pediatric Members less than 18 years of age, skip to question 6.***

**1.** Please indicate member's diagnosis:

- ☐ Insulin dependent Type 1 Diabetes
- ☐ Insulin dependent Type 2 Diabetes
- ☐ Insulin dependent Gestational Diabetes
- ☐ Other_______________________________________________________________________

**2.** Has the member/caregiver received training and support for the requested device in the previous 12 months or is the member/caregiver schedule to receive training within the next 30 days?

☐ Yes ☐ No

**[NOTE TO PRESCRIBER: If training is required for this member, please contact the diabetes educator at Molina Healthcare, Inc. at 804-297-4327 to schedule outreach from the health plan.]**

**3.** Does the member/caregiver have the ability to perform self-monitoring of blood glucose in order to calibrate the monitor and, if needed, verify readings if discordant from their symptoms?

☐ Yes ☐ No

**4.** Has the member/caregiver been counseled on potential drugs/substances that can falsely raise or lower CGM glucose levels, such as acetaminophen, aspirin or vitamin C?

☐ Yes ☐ No

**5.** Please indicate if any of the following are applicable to the member (check all that apply):

- ☐ Member has persistent, recurrent unexplained severe hypoglycemia events
- ☐ Member has hypoglycemic unawareness
- ☐ Member has episodes of ketoacidosis
- ☐ Member has been hospitalized for uncontrolled glucose levels
- ☐ Member has frequent, nocturnal hypoglycemia despite appropriate modifications in insulin therapy
- ☐ Member is compliant with insulin injections that are required at least daily
- ☐ Member is using an insulin pump
- ☐ Member has a diagnosis of gestational diabetes

**Pediatric Members (Less than 18 years of age):**

**6.** Please indicate member's diagnosis:

- ☐ Insulin dependent Type 1 Diabetes
- ☐ Insulin dependent Type 2 Diabetes
- ☐ Insulin dependent Gestational Diabetes
- ☐ Other_______________________________________________________________________

**7.** Has the member/caregiver received training and support for the requested device in the previous 12 months or is the member/caregiver schedule to receive training within the next 30 days?

☐ Yes ☐ No

**[NOTE TO PRESCRIBER: If training is required for this member, please contact the diabetes educator at Molina Healthcare, Inc. at 804-297-4327 to schedule outreach from the health plan.]**

*(Form continued on next page.)*



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**Member's Last Name:** | | | | | | | | | | | |

**Member's First Name:** | | | | | | | | | | | |

**8.** Does the member/caregiver have the ability to perform self-monitoring of blood glucose in order to calibrate the monitor and, if needed, verify readings if discordant from their symptoms?
 ☐ Yes ☐ No

**9.** Has the member/caregiver been counseled on potential drugs/substances that can falsely raise or lower CGM glucose levels, such as acetaminophen, aspirin, or vitamin C?
 ☐ Yes ☐ No

**10.** Has the member/caregiver been counseled on the importance of daily use for optimal outcomes?
 ☐ Yes ☐ No

**Reason for non-formulary request, and/or clinical justification for requested drug use** (Please include relevant lab values when appropriate. **Note:** Member chart notes will be requested if further documentation is necessary): ______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Renewal Request:**

1. Please provide documentation (e.g., decreased A1c, decreased hypoglycemic episodes, increased adherence) of improvement in members diabetes control specific to baseline status.

 ______________________________________________________________________________

 ______________________________________________________________________________

 ______________________________________________________________________________

2. For request for replacement of device (RECIEVER), please provide documentation that the receiver is malfunctioning and is out of warranty.

 ______________________________________________________________________________

 ______________________________________________________________________________

 ______________________________________________________________________________

3. Has the prescriber reviewed the member's compliance with the CGM regimen and found that is it at least 80 percent?
 ☐ Yes ☐ No

*(Form continued on next page.)*



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**Member's Last Name:** | | | | | | | | | | | | |

**Member's First Name:** | | | | | | | | | | | | |

**Additional notes**: ____________________________________________

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____________________________________________

____________________________________________

____________________________________________ ____________________

**Prescriber Signature (Required)**

*By signature, the physician confirms the above information is accurate and verifiable by member records.*

**Date**

**Please include ALL requested information; incomplete forms will delay the SA process.** Submission of documentation does NOT guarantee coverage by Molina Healthcare.

The completed form may be **FAXED TO 1-844-278-5731** or you may call (800) 424-4518 (TTY:711)



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