NEBRASKA MEDICAID FEE-FOR-SERVICE
DURABLE MEDICAL EQUIPMENT
PRIOR AUTHORIZATION FORM
CONTINOUS GLUCOSE MONITORING

Nebraska Medicaid covers the Dexcom G6 and Freestyle Libre 2 as **preferred** devices for continuous glucose monitoring (CGM). CGM devices not listed in the fee schedule are considered **non-preferred**.

If the prior authorization request is approved, payment is still subject to all general requirements, including current member eligibility, other insurance, and other program restrictions.

Member information

Last name _____ First name _____ MI _____
Medicaid Member ID # _____ Date of birth _____

Prescriber Information

Last name* _____ First name* _____ MI _____
NPI* _____ NE Medicaid Provider ID _____
Address _____ City _____ State _____ Zip _____
E-mail address
_____

Telephone No.* _____ Fax No.* _____

Dispensing Durable Medical Equipment Provider Information

DMEPOS Name_____
NPI* _____ NE Medicaid Provider ID _____
Address _____ City _____ State _____ Zip _____
E-mail address
_____
Telephone No.* _____ Fax No.* _____
Required

INITIAL Request for CGM: (Check one)

Preferred CGM device requested**:**

☐ **Dexcom G6** ☐ Receiver ☐ Sensor ☐ Transmitter

☐ **Freestyle Libre 2** ☐ Reader ☐ Sensor

HCPC_____ _____ _____

Non-Preferred CGM device requested:

☐ _____ ☐ Receiver ☐ Sensor ☐ Transmitter

HCPC_____ _____ _____

Please provide medical necessity for prescribing the non-preferred CGM device rather than the preferred CGM device: _____

_____

_____

Clinical Indication (Check all that apply)

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other _____

Please complete all of the following:

Is the member currently receiving multiple (three or more) daily doses of insulin? ☐ Yes ☐ No

Is the member currently using an insulin pump? ☐ Yes ☐ No

Is the member being assessed every 6 months by the prescribing healthcare practitioner? ☐ Yes ☐ No

Does the member exhibit any of the following clinical characteristics? (Check all that apply)

☐ Yes

☐ Hemoglobin A1c or blood sugar values are not within target range

☐ Experiencing hypoglycemia unawareness

☐ frequent hypoglycemia or nocturnal hypoglycemia

☐ No. Please explain why the member is a candidate for CGM: _____

_____

Is the member able to hear and view the CGM alerts and respond accordingly?

☐ Yes

☐ No

☐ does the member have a caregiver who is able to do so? ☐ Yes ☐ No

RENEWAL Request for CGM:

Has the member demonstrated improvement in glycemic control?

☐ Yes

☐ No. Please describe why not: _____

_____

Is the member being assessed every 6 months by the prescribing healthcare practitioner?

☐ Yes

☐ No. Please describe why not: _____

_____

Authorization period: **Initial** authorization period is 6 months.

Renewal authorization period is 12 months.

Supplies: Supplies can be provided for 30 days or up to 90 days at a time.

Prescribing Practitioner Signature: With this signature, the prescriber confirms that the information submitted above is accurate and verifiable in the patient's medical records.

Please note: The Department may request medical records to verify the information submitted above.

Printed Name of Prescriber	*Signature of Prescriber (signature of anyone else is not acceptable).*	*Date Signed*

Submit requests to: _____

CGMPA.2022

REPAIR Request for CGM:

Is the CGM owned by the member? ☐ Yes ☐ No

Is the CGM used exclusively by the member? ☐ Yes ☐ No

Is the damage to the CGM caused by member misuse or abuse? ☐ Yes ☐ No

Is the CGM under the manufacturer's warranty? ☐ Yes ☐ No

REPLACEMENT Request for CGM:

Is the CGM malfunctioning? ☐ Yes ☐ No

Does the cost of the required repairs exceed the cost of replacement? ☐ Yes ☐ No

Is the CGM under the manufacturer's warranty? ☐ Yes ☐ No

What is the age of the CGM? Years: _____ Months: _____

Prior authorization requests for Short-term CGM

Clinical Indication (Check all that apply)

☐ Type 1 Diabetes ☐ Type 2 Diabetes ☐ Other _____

Please complete all the following:

Is the member currently receiving multiple (three or more) daily doses of insulin? ☐ Yes ☐ No

Is the member currently using an insulin pump? ☐ Yes ☐ No

Is the member being assessed every 6 months by the prescribing healthcare practitioner? ☐ Yes ☐ No

Does the member exhibit any of the following clinical characteristics? (Check all that apply)

☐ Yes

☐ Hemoglobin A1c or blood sugar values are not within target range

☐Experiencing hypoglycemia unawareness

☐frequent hypoglycemia

☐ No. Please explain why the member is a candidate for Short-term CGM: _____
_____