Prior Authorization form for
Medicare diabetic glucose meters and test strips

This form is for Medicare member PA requests only. It is not to be used for Commercial or Medicaid member's PA requests. Please use this form for prior authorizations that pertain to diabetic glucose meters and test strips. **Fax completed form to 1-508-791-5101 or call 1-508-368-9825, option 5, then option 2.** Services are subject to coverage, benefit, network and contract policies and exclusions.

Patient information

Last name: _____ First name: _____ MI: _____

DOB: _____ Fallon Health ID #: _____

Physician information

Physician name: _____ Specialty: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____ NPI: _____

Medication requested (one medication per form)

☐ New request for Fallon ☐ Renewal for Fallon

Diagnosis ICD-10 code (required): _____

What is the member's most recent hemoglobin A1C? _____ Date _____

Device requested:

Continuous Glucose Monitors:

☐ Freestyle Libre 14 Day reader and sensors

☐ Freestyle Libre 2 reader and sensors

☐ Freestyle Libre 3 sensors

☐ Dexcom G6 receiver, sensors, transmitter system

☐ Dexcom G7 receiver, sensors

Test Strips:

☐ One Touch Verio
(only required if exceeding the quantity limit >5 EA per 1 day)

☐ One Touch Ultra
(only required if exceeding the quantity limit >5 EA per 1 day)

Non-preferred test strips (specify brand below)

_____

Current testing frequency: _____

Reason why patient cannot use Fallon-preferred One Touch Products: _____

_____

For Freestyle Libre 14 Day, Freestyle Libre 2, Freestyle Libre 3, Dexcom G6, and Dexcom G7, requests, complete the following:

If renewal, is the member stabilized on the requested device? ☐ Yes ☐ No Date initiated: _____

Has the member been evaluated in-person, or over Medicare approved telehealth visit by treating practitioner within the last six (6) months?

☐ Yes ☐ No

Is member insulin-treated, or does member have a history of problematic hypoglycemia such as recurrent level 2 hypoglycemic events that persist despite multiple attempts to adjust medication(s) and/or modify the diabetes treatment plan, or history of level 3 hypoglycemic event characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia?

☐ Yes ☐ No

For products other than Freestyle Libre 14 Day, Freestyle Libre 2, or Freestyle Libre 3, please provide medically necessary reason why Freestyle Libre products cannot be used _____

_____

Member-requested pre-service denial

Complete this section only for Fallon Medicare Plus™ members when declining to submit a prior authorization for a medication requested by the member. Fallon will notify the submitting physician and member of the determination**. Please provide all information requested.**

1. Medication requested by member: _____

2. Member's reason for request: _____