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

Nebraska Medicaid covers certain Dexcom and Freestyle Libre 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***

<u>INITIAL Request for CGM</u>: (Check one)

Indicate model of preferred CGM device requested**:**

☐ **Dexcom** _____ ☐ Receiver ☐ Sensor ☐ Transmitter

☐ **Freestyle Libre** _____ ☐ 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: Acentra Health Provider Portal https://portal.kepro.com or by fax: 1-800-316-0021

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: _____
_____