

Request for Continuous Glucose Monitoring Device

As the provider requesting a Continuous Glucose Monitoring device on behalf of a Medicaid participant, please attest, attach documentation as necessary and sign the form.

It is required to submit this document along with the pre-payment authorization form (DHMH-4527) when requesting a Continuous Glucose Monitoring device. Please ensure that the prescribing physician signs and dates this form.

Medicaid Participant Information

First Name

Last Name

Date of Birth

**Medical Assistance
Identification No.**

Provider Contact Information

**Provider First and
Last Name**

**Provider Medical
Assistance No.**

Date of Request

Clinical Requirements for Coverage

I, the provider listed above, attest to the following:

The Medicaid participant above has Type 1 diabetes

The MA participant above requires insulin injections at least 3 times a day or an insulin pump to maintain blood sugar control

The MA participant (or caregiver if a child) has demonstrated compliance with a physician ordered diabetic treatment plan including regular self-monitoring of blood glucose at least 4 times a day and multiple alterations in insulin administration regimens

The MA participant (or caregiver if a child) is capable of using a long-term CGM system on a near daily basis;

Select at least one of the following clinical indications:

The MA participant has frequent documented severe hypoglycemia (less than 50 mg/dl)

The MA participant has hypoglycemic unawareness that requires assistance from another person to administer oral carbohydrate, glucagon, or other resuscitative actions

The MA participant has HbA1c levels $\geq 7.0\%$

Replacement of Continuous Glucose Monitoring System Components

The replacement of an existing continuous glucose monitoring system component is medically necessary for an MA participant with type 1 diabetes when there is **BOTH** documentation confirming that the monitor/component is malfunctioning, is no longer under warranty and cannot be repaired and an evaluation by the health care provider managing the diabetes within the last six months that includes a recommendation supporting continued use of a continuous glucose monitor.

**I, the provider listed
above, attest to the
following
replacement
criteria:**

There is documentation confirming that the monitor/
component is malfunctioning, is no longer under warranty
and cannot be repaired, and

Within the last six months, the health care provider managing
the diabetes evaluated and the recommendation supports
continued use of a continuous glucose monitor.

I certify that I am the endocrinologist providing care for this Medicaid participant and that the medical necessity information contained in this document is true, accurate and complete, and to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Provider Signature

Date