



MEDICAID / CHIP
PHARMACY PRIOR AUTHORIZATION REQUEST FORM

Continuous Glucose Monitors (CGMs)

Phone: 866-841-7659

Fax back to: 866-240-3712

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL DELAY the review process.

Member Name:		Prescriber Name:	
Member ID Number:	Fax:	Phone:	
Date of Birth:	Office Contact:		
Member Phone Number:	NPI:	PA PROMISe ID:	
Address:	Address:		
City, State ZIP:	City, State ZIP:		
Line of Business: ☐ Medicaid ☐ CHIP	Specialty Pharmacy (if applicable):		
Drug Name:	Strength:		
Quantity:	Refills:		
Directions:			
Diagnosis Code:	Diagnosis:		
Jefferson Health Plans' maximum approval time is 12 months but may be less depending on the criteria..			

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. The member has a diagnosis of diabetes.

☐ Yes

☐ No

Q2. The request is for a preferred Continuous Glucose Monitoring Product.

☐ Yes

☐ No

Q3. For a non-preferred Continuous Glucose Monitoring Product, one of the following:

☐ Has a history of therapeutic failure of the preferred Continuous Glucose Monitoring Products

☐ Requires a non-preferred Continuous Glucose Monitoring Product for compatibility with their insulin delivery device.

Q4. Additional Information:

Prescriber Signature

Date

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