

TRICARE Prior Authorization Request Form for  
Continuous Glucose Monitoring (CGM) Systems (**Dexcom G6, FreeStyle Libre 2**)



6701

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) TRICARE pharmacy program (TPHARM). Express Scripts is the TPHARM contractor for DoD.

- The provider may **call**: 1-866-684-4488  
or the completed form may be **faxed** to:  
1-866-684-4477

- The patient may attach the completed form  
to the prescription and **mail** it to: **Express Scripts, P.O. Box 52150, Phoenix, AZ 85072-9954**  
or **email** the form only to:  
**TPHarmPA@express-scripts.com**

Initial and renewal prior authorization expires after 1 year. For renewal of therapy an initial Tricare prior authorization approval is required.

**Step 1** Please complete patient and physician information (please print):

<b>1</b>	Patient Name: _____	Physician Name: _____
	Address: _____	Address: _____
	Sponsor ID # _____	Phone #: _____
	Date of Birth: _____	Secure Fax #: _____

**Step 2** Please complete the clinical assessment:

<b>1.</b> Has the patient received this product under the TRICARE PHARMACY benefit in the last 6 months? This does not include use of a CGM through other methods including DME. Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested product.	<input type="checkbox"/> Yes (prior use will be verified) Proceed to question 2	<input type="checkbox"/> No Proceed to question 8
<b>2.</b> Is there confirmation that the patient has seen an endocrinologist or diabetes management expert at least once within the past year? Diabetes management expert is defined as: licensed independent practitioner experienced in the management of insulin dependent diabetics requiring basal and bolus dosing or a pump and familiar with the operation and reports necessary for proper management of continuous glucose monitoring systems. This is a self-certification.	<input type="checkbox"/> Yes proceed to question 3	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>3.</b> Is there confirmation that the patient has utilized CGM daily?	<input type="checkbox"/> Yes proceed to question 4	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>4.</b> Will the provider and patient assess the usage of self-monitoring of blood glucose (SMBG) test strips at every visit, with the goal of minimizing/discontinuing use?	<input type="checkbox"/> Yes proceed to question 5	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
<b>5.</b> Does the patient continue to agree to share data with managing healthcare professional for the purposes of clinical decision making?	<input type="checkbox"/> Yes proceed to question 6	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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6. Does the patient have Type 2 diabetes mellitus?	<input type="checkbox"/> Yes proceed to question 7	<input type="checkbox"/> No <b>Sign and date below</b>
7. Does the patient continue to require daily basal and prandial insulin injections?	<input type="checkbox"/> Yes <b>Sign and date below</b>	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
8. Is the requested product prescribed by an endocrinologist or diabetes management expert? Diabetes management expert is defined as: licensed independent practitioner experienced in the management of insulin dependent diabetics requiring basal and bolus dosing or a pump and familiar with the operation and reports necessary for proper management of continuous glucose monitoring systems. This is a self-certification.	<input type="checkbox"/> Yes proceed to question 9	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
9. Does the patient have a diagnosis of Type 1 diabetes mellitus OR Type 2 diabetes mellitus?	<input type="checkbox"/> Yes proceed to question 10	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
10. Is the patient using basal and prandial insulin injections?	<input type="checkbox"/> Yes proceed to question 14	<input type="checkbox"/> No proceed to question 11
11. Is the patient using a continuous subcutaneous insulin infusion (such as insulin pump)?	<input type="checkbox"/> Yes proceed to question 14	<input type="checkbox"/> No proceed to question 12
12. Does the patient have a diagnosis of Type 2 diabetes mellitus?	<input type="checkbox"/> Yes proceed to question 13	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
13. Is the patient receiving insulin therapy and has a history of severe hypoglycemia episodes requiring medical intervention?	<input type="checkbox"/> Yes proceed to question 14	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
14. Has documentation been submitted to confirm the patient's diagnosis?  NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	<input type="checkbox"/> Yes proceed to question 15	<input type="checkbox"/> No <b>STOP</b> Coverage not approved
15. Has documentation been submitted to confirm the patient's medication history, including use of insulin?  NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.	<input type="checkbox"/> Yes proceed to question 16	<input type="checkbox"/> No <b>STOP</b> Coverage not approved

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<p><b>16. Has documentation been submitted to confirm completion of a comprehensive diabetes education program for the patient?</b></p> <p>NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.</p>	<p><input type="checkbox"/> Yes proceed to question 17</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>17. Has documentation been submitted to confirm that the patient agrees to wear CGM as directed?</b></p> <p>NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.</p>	<p><input type="checkbox"/> Yes proceed to question 18</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>18. Has documentation been submitted to confirm that the patient agrees to share device readings with managing healthcare professional for overall diabetes management?</b></p> <p>NOTE: Medical documentation specific to your response to this question must be attached to this case or your request could be denied.</p>	<p><input type="checkbox"/> Yes proceed to question 19</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>19. Will the provider and patient assess the usage of self-monitoring of blood glucose (SMBG) test strips, with the goal of minimizing/discontinuing use?</b></p>	<p><input type="checkbox"/> Yes proceed to question 20</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>20. What is the requested product?</b></p>	<p><input type="checkbox"/> Dexcom G6 proceed to question 21</p>	<p><input type="checkbox"/> FreeStyle Libre 2 proceed to question 22</p>
<p><b>21. Is the patient 2 years of age or older?</b></p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>
<p><b>22. Is the patient 4 years of age or older?</b></p>	<p><input type="checkbox"/> Yes Sign and date below</p>	<p><input type="checkbox"/> No <b>STOP</b> Coverage not approved</p>

**Step 3** I certify the above is true to the best of my knowledge. Please sign and date:

\_\_\_\_\_  
Prescriber Signature

\_\_\_\_\_  
Date

[20 June 2022]