Print Reset

Magellan Rx MANAGEMENT

NYRx the Medicaid Pharmacy Program

Continuous Glucose Monitor (CGM) Prior Authorization Worksheet

Fax Number: 1-800-268-2990

Processing may be delayed if information submitted is illegible or incomplete. If your fax includes the standardized fax form, only the **Member Name, DOB, ID,** and **Clinical Criteria** need to be completed and faxed as an attachment to process your request.

ENROLLEE INFORMATION

Enrollee Last Name: _____

Enrollee First Name: _____

Date of Birth: _____

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): _____

Enrollee Street Address: _____

City: _____ State: _____ Zip: _____

PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI Number: _____

Board-Certified Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

Enrollee's Full Name: _____

REQUESTED DRUG – CGM INFORMATION

Drug Name: _____

Select the requested drug below:

- ☐ Freestyle Libre 14 Day Reader
- ☐ Freestyle Libre 14 Day Sensor
- ☐ Freestyle Libre 2 Sensor
- ☐ Freestyle Libre 2 Reader
- ☐ Freestyle Libre 3 Sensor
- ☐ Dexcom G6 Receiver
- ☐ Dexcom G6 Sensor
- ☐ Dexcom G6 Transmitter
- ☐ Dexcom G7 Receiver
- ☐ Dexcom G7 Sensor

Quantity: _____

Refills: _____

Directions: _____

Is the patient established on this product?

☐ Yes ☐ No

If **Yes**, date therapy was initiated: _____

CLINICAL CRITERIA – DIAGNOSIS

1. What is the patient's diagnosis?
   - ☐ Gestational Diabetes (Stop here if patient has gestational diabetes.)
   - ☐ Diabetes Mellitus Type 1
   - ☐ Diabetes Mellitus Type 2
   - ☐ Other: _____
2. Does the patient need to administer insulin with frequent dosing adjustments or is the patient on an insulin pump?
   - ☐ Yes ☐ No

   If **No**, provide rationale:

Enrollee's Full Name: _____

3. Has the patient received adequate education regarding device calibration and monitor alerts?
   ☐ Yes ☐ No
4. Is there a scheduled follow-up visit with the patient to assess the regimen within the next 6 months?
   ☐ Yes ☐ No

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

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Prior Authorization Call Line: 1-877-309-9493

Billing Questions: 1-800-343-9000. For clinical questions or Clinical Drug Review Program questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.

For the Preferred Diabetic Supply list, please visit:
https://newyork.fhsc.com/downloads/providers/NYRx_PDSP_preferred_supply_list.pdf