Field Name	Field Description
Prior Authorization Group Description	**Continuous Glucose Monitors**
Drugs	Preferred: Freestyle Libre **14 Day**, Freestyle Libre 2, **FreeStyle Libre 3, Dexcom G6** Non-Preferred: ~~Dexcom G6,~~ Eversense (Sensor, Transmitter, and Reader components) And any newly marketed product in this class **This policy does not apply to continuous glucose monitor/insulin pump combination products reviewed and/or covered by the Medical Benefit including, but not limited to, the MiniMed. Requests for these products are referred to the plan's Utilization Management team for Review**
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	Diabetes not treated with insulin
Required Medical Information	See "Other Criteria"
Age Restrictions	Patient must be age appropriate per prescribing information (PI)
Prescriber Restrictions	**N/A**~~Prescribed by or in consultation with an endocrinologist, certified diabetic educator, or an obstetrician/gynecologist~~
Coverage Duration	If all of the criteria are met, the request will be approved for **6** ~~12~~ months. ~~If the criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.~~
Other Criteria	**Initial Authorization** • ~~Diagnosis – diabetes~~ • **Member meets ONE** of the following: o **Diagnosis of diabetes which requires the use of insulin more than two times daily** o **Evidence of level 2 or level 3 hypoglycemia** o **Diagnosis of glycogen storage disease type 1a** o ~~Child or adolescent with type 1 diabetes~~ o ~~Treatment with insulin via a compatible infusion pump~~ o ~~Member is diagnosed with gestational diabetes and treated with insulin therapy~~ o ~~Treatment with multiple daily doses of insulin requiring glucose testing 3 or more times per day and one of the following~~ ▪ ~~Persistently inadequate glycemic control defined as EITHER: HbA1C ≥ 7% on multiple consecutive readings~~

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Revision/Review Date ~~5~~**7**/2022	~~with one being within the last 3 months OR frequent bouts of hypoglycemia~~ ~~▪ Hypoglycemia unawareness~~ • If the request is for a non-preferred product, trial and failure of or medical reason why patient cannot use a preferred product. • If member is continuing use of a non-preferred CGM ~~and requesting non-preferred sensors/transmitters only~~, trial of **a** preferred **CGM** ~~sensors/transmitters~~ first ~~are~~**is** not required **Reauthorization** • **Prescriber attests member has attended regular follow-up visits at least once every six months and continues to benefit from the use of a continuous glucose monitor** ~~▪ One of the following:~~ ~~o Child or adolescent with type 1 diabetes – Approve~~ ~~o Documentation of positive clinical response (i.e. improved HbA1C or reduced frequency of severe hypoglycemia episodes)~~ **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**