TRICARE Prior Authorization Request Form for

# Continuous Glucose Monitoring (CGM) Systems **(Dexcom G6, Dexcom G7, FreeStyle Libre 2, FreeStyle Libre 3, FreeStyle Libre 3 Plus sensor)**

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.

PLEASE NOTE: For Active Duty Service Members, even if coverage will NOT BE APPROVED per this form, it still must be initially submitted to the TPharm Contractor for review. Subsequent reconsideration is allowed at the appropriate Military Treatment Facility.

For initial review by the TPharm Contractor;

- 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):

| | | | |
|---|---|---|---|
| Patient Name: | | Physician Name: | |
| Address: | | Address: | |
| | | | |
| Sponsor ID # | | Phone #: | |
| Date of Birth: | | Secure Fax #: | |

## Step 2

**Please complete the clinical assessment:**

| | | |
|---|---|---|
| **1. Is the requested medication being used for diabetes?** | ☐ Yes<br>proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. 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.* | ☐ Yes<br>(prior use will be verified)<br>proceed to question **3** | ☐ No<br>proceed to question **8** |
| **3. Is there confirmation that the patient has utilized CGM daily?** | ☐ Yes<br>proceed to question **4** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. 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?** | ☐ Yes<br>proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. Does the patient continue to agree to share data with managing healthcare professional for the purposes of clinical decision making?** | ☐ Yes<br>proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |

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| | | |
|---|---|---|
| **6. Does the patient have Type 2 diabetes mellitus?** | ☐ Yes<br>proceed to question **7** | ☐ No<br>proceed to question **8** |
| **7. Does the patient continue to require daily basal or prandial insulin injections?** | ☐ Yes<br>proceed to question **8** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **8. Is the patient using basal or prandial insulin injections?** | ☐ Yes<br>proceed to question **9** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. Please document the following:**<br>**Insulin product: _____ Date last filled _____**<br>**Note: the patient must have filled an insulin prescription within the past 180 days.**<br>**Sign and date below** | | |

**Step 3**

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

_____ _____
Prescriber Signature Date

[12 Feb 2025]