NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services
Nebraska Medicaid Fee-For-Service Pharmacy Benefit Prior Authorization Form Continuous Glucose Monitoring
Effective January 1, 2023

Nebraska Medicaid covers the Dexcom G6 and Freestyle Libre 2 as preferred devices for continuous glucose monitoring (CGM). CGM devices not listed in the fee schedule are considered non-preferred.

If the prior authorization request is approved, payment is still subject to all general requirements, including current member eligibility, other insurance, and other program restrictions.

Member Information

Last Name	First Name	MI

Medicaid Member ID #	Date of Birth

Prescriber Information

Last Name*	First Name*	MI

NPI*	NE Medicaid Provider ID

Address

City	State	Zip

E-mail Address

Telephone No.*	Fax No.*

Dispensing Pharmacy Information

Pharmacy Name

NPI*	NE Medicaid Provider ID

Address

City	State	Zip

E-mail Address

Telephone No.*	Fax No.*

**** Required Fields***

INITIAL Request for CGM: (Check one)

Preferred CGM device requested:

☐ **Dexcom G6** ☐ Receiver ☐ Sensor ☐ Transmitter

☐ **Freestyle Libre 2** ☐ Reader ☐ Sensor

NDC

_____ _____ _____

Non-Preferred CGM device requested:

☐ _____ ☐ Receiver ☐ Sensor ☐ Transmitter

NDC

_____ _____ _____

Please provide medical necessity documentation for prescribing the non-preferred CGM device rather than the preferred CGM device:

Clinical Indication (Check all that apply):

☐ Type 1 Diabetes ☐ Type 2 Diabetes

☐ Other_____

What is the member's most recent hemoglobin A1c:	Date of Test

Please complete all of the following:

Is the member currently receiving multiple (three or more) daily does of insulin?

☐ Yes ☐ No

Is the member currently using an insulin pump?

☐ Yes ☐ No

Is the member being assessed every 6 months by the prescribing healthcare practitioner?

☐ Yes ☐ No

Does the member exhibit any of the following clinic characteristics?

☐ Yes If YES, check all that apply:

- ☐ A hemoglobin A1c or blood sugar values are not within target range
- ☐ Experiencing hypoglycemia unawareness
- ☐ Frequent hypoglycemia or nocturnal hypoglycemia

☐ No If NO: please explain why the member is a candidate for CGM:

Is the member able to hear and view the CGM alerts and respond accordingly?

☐ Yes

☐ No

☐ Does the member have a caregiver who is able to do so? ☐ Yes ☐ No

RENEWAL Request for CGM:

Has the member demonstrated improvement in glycemic control?

☐ Yes ☐ No

If no, please describe why not:

Is the member being assessed every 6 months by the prescribing healthcare practitioner?

☐ Yes ☐ No

If no, please describe why not:

Authorization Period:

Initial authorization period is 12 months.
Renewal authorization period is 12 months.

Supplies:

Supplies can be provided for 30 days or up to 90 days at a time.

Prescribing Practitioner Signature: With this signature, the prescriber confirms that the information submitted above is accurate and verifiable in the patient's medical records.

Please note: The Department may request medical records to verify the information submitted above

Printed Name of Prescriber:

Signature of Prescriber (Signature of anyone else is NOT acceptable).	Date Signed

Submit requests to:
Magellen Medicaid Administration, Inc.
Fax: 1-866-759-4115
Telephone: 1-800-241-8335

REPLACEMENT Request for CGM

Is the CGM malfunctioning?

☐ Yes ☐ No

Does the cost of the required repairs exceed the cost of replacement?

☐ Yes ☐ No

Is the CGM under the manufacturer's warranty?

☐ Yes ☐ No

What is the age of the CGM?

Years:_____ Months:_____