

Nebraska Medicaid covers certain Dexcom and Freestyle Libre devices as preferred devices for continuous glucose monitoring (CGM). CGM devices not listed in the [look up tool](#) 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**
 Receiver
 Sensor
 Transmitter
 Freestyle Libre
 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 Gestational DM
 Other _____

What is the member's most recent hemoglobin A1c:

Date of Test

Please complete all of the following:

Is the member currently insulin-treated?

Yes No

Is the member being assessed every 6 months by the prescribing healthcare practitioner for adherence to a comprehensive diabetes treatment plan?

Yes No

Does the member exhibit any of the following clinical characteristics?

Yes If YES, check all that apply:

Recurrent (more than one) hypoglycemic events with blood glucose less than 54mg/dl (3.0mmol/L) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan?

History of one hypoglycemic event with blood glucose less than 54mg/dl (3.0mmol/L) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia.

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

RENEWAL Request for CGM:

Is the member being assessed every 6 months by the prescribing healthcare practitioner for adherence to a comprehensive diabetes treatment plan?

Yes No

If no, please describe why not:

Authorization Period:

Initial authorization period is 6 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:
Prime Therapeutics State Government Solutions, LLC
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: _____
