BlueCross BlueShield of North Carolina

Diabetes Testing Supplies – Continuous Glucose Monitoring (CGM) Systems

Medicare Part B Coverage Request Form

To submit request electronically, please go to providerportal.surescripts.net/ProviderPortal/login **OR** covermymeds.com using Plan/PBM Name "BCBS NC"

Fax: 888-446-8535

Mail: Blue Cross NC, ATTN: Part D Coverage Determination
P.O. Box 2251, Durham, NC 27702-2251

Call: 888-298-7552 Blue Medicare Rx
888-296-9790 Blue Medicare HMO/PPO

Incomplete Form May Delay Processing

Prescriber Information			Patient Information
Physician Name:		NPI #:	Patient Name:
Office Contact Person:			Patient ID #:
Office Phone #:	Office Fax #:		Home Phone #:
Address:			Sex: ☐ Female ☐ Male
City:	State:	Zip:	DOB:

Please answer questions below

THIS FORM IS FOR A MEDICARE PART B (MEDICAL) REQUEST ONLY

1. Is this request for an expedited review? ☐ Yes ☐ No
   Check the "Yes" box to request an expedited review if the enrollee or his/her physician or other prescriber believes that waiting for a decision under the standard time frame may place the enrollee's life, health, or ability to regain maximum function in serious jeopardy.

2. Please indicate the requested brand of continuous glucose monitor/supplies:
   ☐ Medtronic Enlite ☐ Medtronic Guardian ☐ Medtronic Paradigm
   ☐ Other (please specify): _____

3. Does the patient have diabetes mellitus? ☐ Yes ☐ No

4. Is the patient on insulin? ☐ Yes ☐ No
   A. **If NO**, does the patient have a documented history of recurrent (more than one) level 2 hypoglycemic events (glucose < 54mg/dL) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan? ☐ Yes ☐ No
      i. **If NO to 4.A.**, does the patient have a documented history of at least one level 3 hypoglycemic event (glucose < 54mg/dL) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia? ☐ Yes ☐ No

5. Has the patient been previously approved for the requested continuous glucose monitor (CGM) through this plan's Prior Authorization process?
   A. **If YES**, has the patient had an in-person or telehealth visit with the provider within the last 6 months to assess adherence to their diabetes treatment regimen and use of their CGM device? ☐ Yes ☐ No
   B. **If NO**, what was the date of the patient's last in-person or telehealth visit with the provider to evaluate their diabetes? ____/____/_____

6. Has the patient tried and failed a Dexcom brand CGM? ☐ Yes ☐ No
   A. **If NO,** what limitations does this patient have precluding the use of this preferred brand (include any additional clinical rationale for requesting coverage)?:
   _____
   _____

PLEASE CONTINUE TO NEXT PAGE

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7. Has the patient tried and failed a Freestyle Libre brand CGM? ..... ☐ Yes ☐ No
   A. If NO, what limitations does this patient have precluding the use of this preferred brand (include any additional clinical rationale for requesting coverage)?:
   _____
   _____

I certify that I have appropriate authority to request a coverage decision for the medication indicated on this request. I further certify that the patient's medical records accurately reflect the information provided. I understand that Blue Cross NC may request medical records for this patient at any time in order to verify this information.

Physician Signature:_____ Date: _____

Updated: 01/01/2025