Freestyle Libre Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			**Provider Information** (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:

Medication Information (required)		
Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)	
1. Is the patient 18 years of age or older?	❑ Yes ❑ No
2. Does the patient have a diagnosis of Type 1 or Type 2 Diabetes?	❑ Yes ❑ No
3. Is the patient currently enrolled in or has completed a comprehensive diabetic education program within the past 6 months?	❑ Yes ❑ No
4. Does the patient have a history of using a blood glucose monitor and performing frequent testing?	❑ Yes ❑ No
5. Is the patient compliant with the recommended diabetes medication regimen?	❑ Yes ❑ No
6. Does the patient require oral anti-diabetic medication, non-insulin injectable anti-diabetic medication and/or insulin injections?	❑ Yes ❑ No
7. Does the patient have glycosylated hemoglobin A1c (HbA1c) values of 7 or greater?	❑ Yes ❑ No
8. Does the patient have documented inadequate glycemic control despite compliance with frequent self-testing and fasting hyperglycemia (greater than 150 mg/dL) or frequent recurring episodes of severe hypoglycemia (less than 70 mg/dL)?	❑ Yes ❑ No
9. Does the patient have documented hypoglycemia unawareness, episodes of ketoacidosis, or hospitalizations for uncontrolled glucose levels?	❑ Yes ❑ No
10. Does the patient have frequent nocturnal hypoglycemia despite appropriate modifications in insulin therapy?	❑ Yes ❑ No
11. Is the patient a pregnant female with Type I or Type II or one that has developed gestational diabetes that requires insulin therapy?	❑ Yes ❑ No

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

Freestyle Libre Prior Authorization Request Form (Page 2 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern

OptumRx has partnered with CoverMyMeds to receive prior authorization requests,
saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.