



Glucose Monitoring Supplies

Fax completed form to: (855) 840-1678
If this is an URGENT request, please call (800) 882-4462

PHYSICIAN INFORMATION			PATIENT INFORMATION		
* Physician Name:			*Due to privacy regulations we will not be able to respond via fax with the outcome of our review unless all asterisked (*) items on this form are completed.*		
Specialty:	* DEA, NPI or TIN:				
Office Contact Person:			* Patient Name:		
Office Phone:			* Cigna ID:		* Date of Birth:
Office Fax:			* Patient Street Address:		
Office Street Address:			City:	State:	Zip:
City:	State:	Zip:	Patient Phone:		
Urgency: <input type="checkbox"/> Standard <input type="checkbox"/> Urgent (In checking this box, I attest to the fact that applying the standard review time frame may seriously jeopardize the customer's life, health, or ability to regain maximum function)					
Supplies Requested: <div style="display: flex; justify-content: space-between;"> <div style="width: 48%;"> <p>Therapeutic:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dexcom G6 sensors <input type="checkbox"/> Dexcom G6 receiver <input type="checkbox"/> Dexcom G6 transmitter <input type="checkbox"/> Dexcom G7 Sensors <input type="checkbox"/> Dexcom G7 Receiver <input type="checkbox"/> Dexcom G7 15-day sensors <input type="checkbox"/> Freestyle Libre 14-day sensors <input type="checkbox"/> Freestyle Libre 10-day sensors <input type="checkbox"/> Freestyle Libre 2 sensors <input type="checkbox"/> Freestyle Libre 2 Plus sensors <input type="checkbox"/> Freestyle Libre 3 sensors <input type="checkbox"/> Freestyle Libre 3 Plus sensors <input type="checkbox"/> Freestyle Libre 2 reader <input type="checkbox"/> Freestyle Libre 3 reader <input type="checkbox"/> Freestyle Libre 14-day reader <input type="checkbox"/> Freestyle Libre 10-day reader <input type="checkbox"/> Minimed Instinct sensor <input type="checkbox"/> Simplera Sensor <input type="checkbox"/> Simplera Sync Sensor <p>HCPC/CPT Codes:</p> <ul style="list-style-type: none"> <input type="checkbox"/> A4238 <input type="checkbox"/> A9276 <input type="checkbox"/> A9277 <input type="checkbox"/> A9278 <input type="checkbox"/> E2102 <input type="checkbox"/> A4239 <input type="checkbox"/> E2103 <input type="checkbox"/> Other: _____ </div> <div style="width: 48%;"> <p>Non-Therapeutic:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Dexcom G4 receiver kit <input type="checkbox"/> Dexcom G4 (Ped) receiver kit <input type="checkbox"/> Dexcom G4 receiver-share kit <input type="checkbox"/> Dexcom G4 (Ped) receiver-share kit <input type="checkbox"/> Dexcom G4 transmitter kit <input type="checkbox"/> Dexcom G5 receiver kit <input type="checkbox"/> Dexcom G5-G4 sensor kit <input type="checkbox"/> Dexcom G5 transmitter kit <input type="checkbox"/> Dexcom receiver kit <input type="checkbox"/> Enlite glucose sensor <input type="checkbox"/> Enlite System kit <input type="checkbox"/> Eversense Sensor-Holder <input type="checkbox"/> Eversense Smart transmitter <input type="checkbox"/> Freestyle Navigator sensor kit <input type="checkbox"/> Guardian Connect transmitter <input type="checkbox"/> Guardian Link 3 transmitter <input type="checkbox"/> Guardian Sensor 3 <input type="checkbox"/> Guardian 4 Sensor <input type="checkbox"/> Guardian 4 Transmitter <input type="checkbox"/> Minilink Real-Time transmitter <input type="checkbox"/> Minimed 630G Guardian Start Kit <input type="checkbox"/> Paradigm Real-time system <input type="checkbox"/> Sof-Sensor <input type="checkbox"/> Other: please specify - _____ </div> </div>					
Directions for use: ICD10:		Quantity:		Duration of therapy:	
Where will the supplies be obtained? <input type="checkbox"/> Express Scripts Pharmacy** <input type="checkbox"/> Retail pharmacy <input type="checkbox"/> DME Vendor <input type="checkbox"/> Other (please specify):					

Servicing Provider/Dispensing Vendor:

Name: _____ State: _____ Tax ID: _____
Address (city, state, zip code): _____
Phone: _____ Fax: _____

Is the requested medication for a chronic or long-term condition for which the prescription medication may be necessary for the life of the patient? Yes No

Diagnosis:

- Type 1 diabetes mellitus (DM)
- Type 2 diabetes mellitus (DM)
- Other (Please specify): _____

Clinical Information:

Is the patient on ANY of the following insulin regimens: 1. multiple daily injections; 2. long-acting basal insulin (for example: glargine, detemir, degludec, NPH); or 3. continuous subcutaneous external insulin pump? Yes No

Additional pertinent information:

Attestation: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan or insurer its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature: _____ **Date:** _____

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Our standard response time for prescription drug coverage requests is 5 business days. If your request is urgent, it is important that you call us to expedite the request. View our Prescription Drug List and Coverage Policies online at cigna.com.

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