



Dexcom G6, Freestyle Libre Sensors

Phone: (800) 244-6224
Fax: (800) 390-9745

Notice: Please be sure to complete this form in its entirety. Missing information makes it difficult to approve requests and creates a longer processing time.

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:		

Sensor requested:

- Dexcom G6 sensors
- Freestyle Libre 14-day sensors
- Freestyle Libre 10-day sensors

ICD10:

Directions for use:

Quantity:

Duration of therapy:

Urgency: Standard 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)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:** diabetes mellitus (DM) Other (Please specify):**Clinical Information:**(if DM) Is/Will your patient be on insulin at the same time? Yes No (if on insulin) Is/Will your patient be using a continuous subcutaneous external insulin pump? Yes No (if no pump) Does your patient's insulin regime include both a long-acting or basal insulin (like Basaglar, Lantus, Levemir, Toujeo or Tresiba) AND a rapid-acting or prandial/mealttime insulin (like Admelog, Afrezza, Apidra, Fiasp, Humalog, or Novolog?) Yes No (if Dexcom G6 or Freestyle Libre 10-day) Does your patient need more than 3 sensors every 30 days? Yes No (if Freestyle Libre 14-day) Does your patient need more than 2 sensors every 28 days? Yes No **Additional pertinent information:** (please include clinical reasons for sensors, relevant lab values, etc.)

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: _____

Save Time! Submit online at: <https://cigna.promptpa.com>**Please fax completed form to (800) 390-9745. Urgent requests may be submitted by calling (800) 244-6224.**Our standard response time for prescription drug coverage requests is 2-4 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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