



Glucose Monitoring Supplies

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

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: 45%;"> <p>Therapeutic:</p> <input type="checkbox"/> Dexcom G6 sensors <input type="checkbox"/> Dexcom G6 receiver <input type="checkbox"/> Dexcom G6 transmitter <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 10-day reader <input type="checkbox"/> Freestyle Libre 14-day reader <p>HCPC/CPT Codes:</p> <input type="checkbox"/> A9276 <input type="checkbox"/> A9277 <input type="checkbox"/> A9278 <input type="checkbox"/> K0553 <input type="checkbox"/> K0554 <input type="checkbox"/> Other: _____</div> <div style="width: 45%;"> <p>Non-Therapeutic:</p> <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"/> 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): <div style="text-align: right; font-size: small;"><i>*Cigna's nationally preferred specialty pharmacy</i></div>					
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? <input type="checkbox"/> Yes <input type="checkbox"/> No					

Diagnosis: diabetes mellitus (DM) Other (Please specify):**Clinical Information:**

(if DM) What is your patient's current diabetic regimen? Be sure to include types of insulin used (including the strength), pumps, etc. and how each is dosed daily.

(if DM) Is your patient on insulin?

Yes No

(if on insulin) Is your patient using a continuous subcutaneous external insulin pump?

Yes No

(if no pump) Is the patient receiving more than 1 daily injection of U500 insulin?

Yes No

(if no multiple U500 daily injections) Does your patient's insulin regimen include both a long-acting or basal insulin (like Basaglar, Lantus, Levemir, Soliqua, Semglee, Toujeo, Tresiba, NPH and Xultophy) AND a rapid-acting (prandial/mealtime) insulin (like Admelog, Afrezza, Apidra, Fiasp, Humalog, insulin aspart, insulin lispro or Novolog) –OR- is your patient on a mixed (which is used for both basal and prandial/mealtime) insulin (like Humalog Mix, Humulin, Novolin, Novolog Mix)?

Yes No

Additional pertinent information: *(please include clinical reasons for supplies, 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:** _____

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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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