CONTINUOUS GLUCOSE MONITORING PRODUCTS PRIOR AUTHORIZATION FORM

(form effective 1/1/2026)

Keystone First
Family of Health Plans

Keystone First: Fax to **1-866-497-1387**, or to speak to a representative call **1-800-588-6767**.

Keystone First Community HealthChoices: Fax to **1-855-851-4058**, or to speak to a representative call **1-866-907-7088**.

PRIOR AUTHORIZATION REQUEST INFORMATION

☐ New request ☐ Renewal request	Total # of pages:	
Name of office contact:	Contact's phone number:	Facility contact/phone:

BENEFICIARY INFORMATION

Beneficiary name:		Beneficiary ID#:	DOB:
Street address:			
Apt #:	City/state/zip:	Phone:	Fax:

PHYSICIAN INFORMATION

Physician name:	Physician Tax ID:
Specialty:	Physician NPI:
Street address:	
Suite #: City/state/zip:	
Phone:	Fax:

FACILITY INFORMATION

Facility NPI:		Facility Tax ID#:
Street address:		
Suite #:	City/state/zip:	Treatment setting: ☐ Outpatient (home) ☐ Inpatient

CLINICAL INFORMATION

Product(s) requested:						
☐ Receiver/reader:			Quantity:			
For DME request only						
J-code:	Number of units:	Date of service (MM/DD/YYYY):				
☐ Transmitters:			Quantity:	per	days	Refills:
For DME request only						
J-code:	Number of units:	Date of service (MM/DD/YYYY):				
☐ Sensors:			Quantity:	per	days	Refills:
For DME request only						
J-code:	Number of units:	Date of service (MM/DD/YYYY):				
☐ Other:			Quantity:	per	days	Refills:
For DME request only						
J-code:	Number of units:	Date of service (MM/DD/YYYY):				
Diagnosis *(submit documentation)*:			Dx Code *(required)*:			

INITIAL REQUESTS

Complete all sections that apply to the beneficiary and this request.
Check all that apply and submit documentation for each item.

1. For ALL requests for a Continuous Glucose Monitoring (CGM) Product:
☐ The beneficiary has a diagnosis of diabetes
☐ The beneficiary has a diagnosis other than diabetes for which CGM is medically necessary – *submit documentation supporting the medical necessity of CGM for this beneficiary*

INITIAL REQUESTS *(continued)*

2. For requests for a NON-PREFERRED CGM Product:

☐ The beneficiary is using an insulin delivery device that is compatible with the requested non-preferred CGM Product

☐ The beneficiary has a history of trial and failure of the preferred CGM Products – *(Refer to https://papdl.com/preferred-drug-list for a list of preferred and non-preferred drugs in this class.)*

PLEASE FAX COMPLETED FORM WITH SUPPORTING CLINICAL DOCUMENTATION

Prescriber signature:	Date:

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