CDPHP® Utilization Review Prior Authorization/Medical Exception Form
Continuous Glucose Monitors

Fax or mail this form to:

CDPHP Utilization Review Department, 500 Patroon Creek Blvd., Albany, NY 12206-1057
Fax: (518) 641-3207 • Phone: (518) 641-4100

Please note: If the requirement for prior authorization for a particular service or procedure has been removed by CDPHP, there is no need for you to submit this form for consideration. However, before performing the service or procedure, you must still ensure that your patient meets the medical necessity criteria outlined in the applicable CDPHP Resource Coordination policy. If you believe your patient's situation presents a unique exception to a policy, please submit this form for review, along with clinical documentation, and check the box below.

☐ Medical exception

Date Received: _____ Member Name: _____

Date of Birth: _____ CDPHP Member ID: _____

Diagnosis:

**If DM1: Call provider services to check for coverage; prior authorization is not required for all in network providers. If DM2: Call provider services at (518) 641-3140 to check if prior authorization is required. If required, please fill out and fax this form with clinical documentation to (518) 641-3207.*

☐ New to pump therapy ☐ Not new to pump therapy

What is the request for?:

HGB A1C Date: _____ Result: _____

Medications *(frequency of injections, types of insulin)*:

Frequency of testing at home *(how many times per day)*:

Blood Glucose Ranges *(please provide copies of blood glucose results)*:

Has the member received diabetic education?: ☐ Yes ☐ No