

[Physician Name]
[Clinic/Hospital Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Fax Number]

[Date]

[Insurance Company Name]
[Prior Authorization Department]
[Address]
[City, State, Zip Code]

RE: Prior Authorization Request for Continuous Glucose Monitor (CGM)

Patient Name: [Patient Full Name]
Date of Birth: [DOB]
Member ID: [Insurance ID Number]
Group Number: [Group Number]
Case Reference Number: [If applicable]

To Whom It May Concern,

I am writing to formally request a prior authorization for a Continuous Glucose Monitor (CGM) system for my patient, [Patient Name]. This request is based on medical necessity for the management of [Type 1 / Type 2 / Gestational] Diabetes Mellitus (ICD-10 Code: [Insert Code]).

The patient currently meets the following clinical criteria for CGM therapy:

- The patient requires multiple daily injections of insulin (at least 3 per day) or uses an insulin pump.
- The patient requires frequent adjustment of the insulin treatment regimen based on glucose testing results.
- The patient has experienced frequent unexplained hypoglycemic episodes or hypoglycemic unawareness.
- The patient has not achieved glycemic control despite adherent self-monitoring of blood glucose (SMBG) at least 4 times per day.

The requested device is [Name of Specific CGM System, e.g., Dexcom G6/G7, FreeStyle Libre 2/3].

This technology is essential for this patient to prevent life-threatening hypoglycemic events, reduce glycemic variability, and lower HbA1c levels. Documentation of the patient's glucose logs and recent office notes are attached for your review.

Please contact my office at [Phone Number] if you require additional information to approve this request promptly.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[NPI Number]

Attachments:

1. Clinical Office Notes
2. Recent Lab Results (HbA1c)
3. Blood Glucose Logs