[Physician Name]
[Practice Name]
[Address]
[City, State, Zip Code]
[Phone Number]
[Fax Number]

[Date]

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

RE: Initial Prior Authorization Request for Continuous Glucose Monitoring (CGM) System

Patient Name: [Patient Name]
Date of Birth: [DOB]
Member ID: [Member ID]
Group Number: [Group Number]
ICD-10 Code: [e.g., E11.65, E10.9]

To Whom It May Concern,

I am writing to request prior authorization for a Continuous Glucose Monitoring (CGM) system for my patient, [Patient Name]. This request is for the [Insert Brand/Model Name] system and associated sensors and transmitters.

The patient has a diagnosis of [Diabetes Type] and is currently managed with [Number] or more daily injections of insulin or an insulin pump. Despite adherence to their current treatment plan, the patient continues to experience:

- [Frequent hypoglycemia/Hypoglycemia unawareness]
- [Severe glycemic variability]
- [Inability to meet HbA1c targets]
- [Dawn phenomenon or nocturnal hypoglycemia]

Current clinical data:

- **Most Recent HbA1c:** [Value]% dated [Date]
- **Current Insulin Regimen:** [List Regimen]
- **Frequency of Fingerstick Testing:** [Number] times per day

A CGM system is medically necessary for this patient to improve glycemic control, prevent life-threatening hypoglycemic events, and reduce long-term complications associated with diabetes.

This device will allow for real-time adjustments to insulin dosing and provide alerts for glucose excursions.

Attached please find the patient's recent clinical notes and lab results supporting this request. Please contact my office if you require any additional information.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[NPI Number]