Prior Authorization Criteria for Non-Preferred Continuous Glucose Monitors

Targeted Products:

- Continuous Glucose Monitors (CGMs): Guardian and Eversense

Exclusion Criteria:

- None

Age Restrictions:

- None

Prescriber Restrictions:

- None

Coverage Duration:

- 1 year

Other Criteria:

For Initial Requests - Approve if the member meets all of the following:

1) has diabetes mellitus, AND
2) has tried and had an inadequate experience with both formulary continuous glucose monitor (CGM) systems (Dexcom and Freestyle Libre) or there is a clinical reason all of the formulary CGMs cannot be used, AND
3) the member is treated with insulin at least once per day or has a history of problematic hypoglycemia with documentation of at least one of the following: Recurrent level 2 hypoglycemic events (glucose less than 54mg/dL (3.0mmol/L) that persist despite multiple (2 or more) attempts to adjust medication(s) and/or modify the diabetes treatment plan, or, a history of one level 3 hypoglycemic event (glucose less than 54mg/dL (3.0mmol/L) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia, AND
4) the member (or the members caregiver) must have been properly trained on using the requested CGM as evidenced by the treating practitioner providing a prescription, AND
5) the CGM is prescribed according to its Food and Drug Administration (FDA) indicated use, AND
6) the prescriber has had an in-person visit or approved telehealth visit with the member within the past six months, prior to ordering the CGM, to evaluate their diabetes control.

For Continuation Requests - Approve if the member meets all of the following:

1) has diabetes mellitus, AND

2) has tried and had an inadequate experience with both formulary continuous glucose monitor (CGM) systems (Dexcom and Freestyle Libre) or there is a clinical reason all of the formulary CGMs cannot be used, AND
3) if the treating practitioner conducts an in-person or Medicare-approved telehealth visit with the member to document adherence to their CGM regimen and diabetes treatment plan every six months following the initial prescription of the CGM.

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P.O. Box 51 | Minneapolis, MN 55440

Prior Authorization Criteria for Non-Preferred Diabetic Testing Supplies

Targeted Products:

- Non-Preferred Testing Supply (examples include): Contour test strips, ReliOn test strips, Accu-Chek test strips, TrueTrack test strips, Precision test strips, Freestyle test strips

Exclusion Criteria:

- None

Age Restrictions:

- None

Prescriber Restrictions:

- None

Coverage Duration:

1 year

Other Criteria:

Approve the non-preferred testing supply for a member with diabetes if the prescriber has concluded the member has sufficient training to use the requested device prescribed AND meets one of the following:

1) is using an insulin pump that requires the requested testing supply product for optimal benefit, OR
2) has tried at least two formulary alternative testing supply products (if two unique testing supply products are available), AND the previously tried formulary alternative testing supply products were ineffective in managing the condition listed for use, OR
3) the formulary testing supply products are expected to be less effective than the non-formulary testing supply products OR the formulary products would be likely to cause harm to the patient, OR
4) the member has severe visual impairment AND is requesting a meter with audio capabilities. Examples include but are not limited to the following: Advocate (Redi-Code plus speaking meter), Arkray (Glucocard Expression, Glucocard Shine Express), Foracare (Fora D40D, Fora D40G, For a Gtel, Fora Premium V10 BLE, Fora Test N' Go, Fora Tn'G Voice, Fora V30), Oak Tree Health (EasyMax V, Fortiscare V3), Omnis Health (Embrace Talk), Prodigy (Prodigy Autocode, Prodigy Voice), Relion Premier Voice, OR
5) the member has a manual dexterity impairment severe enough to require the use of a specific glucose monitoring system

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Notice of Nondiscrimination

Aspirus Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. Aspirus Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability or sex.

We provide aids and services at no charge to people with disabilities to communicate effectively with us, such as TTY line, or written information in other formats, such as large print.

If you need these services, contact us at **715.631.7411 (voice)** or toll free at **1.855.931.4850 (voice)**, **715.631.7413 (TTY)**, or **1.855.931.4852 (TTY)**.

We provide language services at no charge to people whose primary language is not English, such as qualified interpreters or information written in other languages.

If you need these services, contact us at the **number on the back of your membership card** or **715.631.7411** or toll free at **1.855.931.4850 (voice)**; **715.631.7413** or toll free at **1.855.931.4852 (TTY)**.

If you believe that Aspirus Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file an oral or written grievance.

Oral grievance

If you are a current Aspirus Health Plan member, please call the number on the back of your membership card. Otherwise please call **715.631.7411** or toll free at **1.855.931.4850 (voice)**; **715.631.7413** or toll free at **1.855.931.4852 (TTY)**. You can also use these numbers if you need assistance filing a grievance.

Written grievance
Mailing Address
Attn: Appeals and Grievances
Aspirus Health Plan
PO Box 51
Minneapolis, MN 55440
Email: cagMA@aspirushealthplan.com
Fax: 715.631.7439

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services 200
Independence Avenue SW
Room 509F, HHH Building Washington, D.C.
20201
1-800-368-1019, 1-800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 715.631.7411/1.855.931.4850（TTY：715.631.7413/1.855.931.4852）。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 715.631.7411/1.855.931.4850 (телетайп: 715.631.7413/1.855.931.4852).

ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 715.631.7411/1.855.931.4850 (መስማት ለተሳናቸው: 715.631.7413/1.855.931.4852).

ဟ်သူဉ်ဟ်သး–နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ်၊ ကျိာ်အတ်မၤစၢၤလ၊ တလာ်ဘူဉ်လာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ.
ကိး 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយា ភាសារ៉ែខ្មរ, រសវាជំនួយរ៉ែផ្នកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរ៉ើអ្នក។ ចូរ ទូរស័ព្ទ 715.631.7411/ 1.855.931.4850 (TTY: 715.631.7413/ 1.855.931.4852)។

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 715.631.7411/1.855.931.4850 (رقم هاتف الصم والبكم: 1.855.931.4852/ 715.631.7413).

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 715.631.7411/1.855.931.4850 (ATS : 715.631.7413/1.855.931.4852).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/ 1.855.931.4852) 번으로 전화해 주십시오.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 715.631.7411/1.855.931.4850 (TTY: 715.631.7413/1.855.931.4852).