BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Pharmacy Policy

Continuous Glucose Monitoring – Unified Formulary

Policy Number: 9.337
Version Number: 1
Version Effective Date: 7/1/2021

Product Applicability	☐ **All Plan+ Products**
Well Sense Health Plan	**Boston Medical Center HealthNet Plan**
☐ New Hampshire Medicaid	☒ MassHealth ACO
	☒ MassHealth MCO
	☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct
	☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy

Reference Table

Products that require PA	No PA
Dexcom G6®	
Freestyle Libre 14 day®	
Freestyle Libre 2®	

The following NDCs are included within the rebate agreement and will usually reject at the pharmacy as prior authorization required. Any NDC that is not listed here is not included in the rebate agreement and therefore will usually reject at the pharmacy level.

Dexcom G6®
08627-0091-11 Dexcom G6 Receiver Kit (GSN 065863)
08627-0016-01 Dexcom G6 Transmitter Kit (GSN 065873)
08627-0053-03 Dexcom G6 Sensor 3-pack (GSN 065744)

Freestyle Libre 14 day® and Freestyle Libre 2®
57599-0000-21 FreeStyle Reader Kit 10 Day (GSN 077832)
57599-0000-19 FreeStyle Sensor Kit 10 Day (GSN 077828)

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57599-0002-00 FreeStyle Reader Kit 14 Day (GSN 077832)
57599-0001-01 FreeStyle Sensor Kit 14 Day (GSN 077828)
57599-0803-00 FreeStyle 2 Reader (GSN 077832)
57599-0800-00 FreeStyle 2 Sensor (GSN 077828)

Procedure[1-35]:

Approval Diagnosis:	• Diabetes Mellitus
Approval Criteria: *Dexcom G6®* *Freestyle Libre 14 day®* *Freestyle Libre 2®*	Prescriber provides documentation of the following: 1. Diagnosis of diabetes mellitus 2. Member's current treatment plan involves testing blood glucose at least 4 times per day* 3. Member is currently receiving multiple daily insulin injections or an insulin pump *(Claims for short acting insulin or concurrent claims for multiple types of insulin are sufficient)*† 4. **ONE** of the following: a. A1c ≥7% or value that does not meet documented target treatment despite diabetic education and adherence to self-monitoring of glucose levels b. Frequent hypoglycemia (or nocturnal hypoglycemia) c. History of hypoglycemic unawareness d. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL. e. History of emergency room visit or hospitalization related to ketoacidosis or hypoglycemia f. Use with compatible insulin pump to achieve glycemic control g. Pregnancy *Notes* ** Members who are nonadherent to the recommended testing may still be approvable if the prescriber states that testing is recommended or prescribed as at least four times daily.* *†Members not receiving insulin due to physical disability, visual impairment, cognitive impairment, or age <18 years may bypass this requirement. Other comorbidities should be evaluated on a case by case basis.*
Denial Criteria:	Cases that do not meet the approval criteria will be denied.
	If a request is denied and the prescriber has additional clinical documentation, a **new** prior authorization request must be submitted.
Duration of Authorization:	Prior authorization may be issued for **1 year.**
Recertification Criteria:	Recertification requests may be approved for up to **1 year** if BOTH of the following criteria are met: 1. Prescriber documents improvement in diabetic control/relative stability (e.g., provider attestation or A1c improvement can be considered to meet this requirement) 2. Provider attestation that the member's CGM data has been reviewed and is being used to monitor or adjust antidiabetic treatment plan

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Appendix:

Stability

Stability on a continuous glucose monitoring device may generally be accepted for approval if the member has an appropriate diagnosis. Stability may be determined based on consistent monthly claims, provider attestation, or documentation in medical records. However, stability is not sufficient to bypass approval criteria for members noted to be stabilized on a continuous glucose monitor using samples or professional (office owned) continuous glucose monitors.

Grandfathering

Information is not applicable

Responsibility and Accountability

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
5/13/2021	7/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
5/13/2021	Created policy for MH Unified Formulary, policy date 3/1/21	7/1/2021	P&T Committee

Next Review Date

5/2022

Other Applicable Policies

References

Reference to Applicable Laws and Regulations, if Any

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