TeamstersCare Continuous Glucose Monitoring Systems Prior Authorization Form

- Complete and fax to 617-241-5025.
- Standard response time is 3 to 5 business days from date received.

PATIENT INFORMATION	
Patient Name:	
Date of Birth:	TeamstersCare ID#:
Patient Address:	Patient Phone:

PROVIDER INFORMATION	
Provider Name:	
Contact Person (If different than prescriber):	
Office Phone:	Office Fax:

MEDICATION INFORMATION	
Product Name:	
Pertinent Diabetic History (e.g., hospitalizations, hypoglycemic events, etc.) **Please send a copy of most recent office visit notes**	
# of Finger Sticks / day :_____	A1C _____Date_____
Diabetic Medications/Insulins:	
Provider's Signature:	Date:

FOR TEAMSTERSCARE USE ONLY	
Eligibility Verified ☐	**Notes:**
Program: Active ☐ ERMP ☐ RRX☐	
Prior PA? Yes☐ No ☐ If Yes, Date:	
Form Complete/Legible ☐	
Authorized ☐ Pended ☐ Denied ☐	
Patient Notified ☐ By: Date:	
Letter Sent ☐ By: Date:	

Rev 04-2024

	Reviewer : **Date:**