Continuous Glucose Monitoring (CGM)

Goal(s):

- Restrict use of CGM to medically appropriate conditions funded under the Oregon Health Plan
- Promote use that is consistent with the Health Evidence Review Commission guideline note 108

Length of Authorization:

Up to 12 months

Requires PA:

- All continuous glucose monitoring supplies

Covered Alternatives:

- Current PMPDP preferred drug list per OAR 410-121-0030 at www.orpdl.org
- Searchable site for Oregon FFS Drug Class listed at www.orpdl.org/drugs/

Table 1. Quantity limits for continuous glucose monitoring

Product	Receiver/Reader*	Transmitter	Sensors
Cost-effective CGM			
Dexcom 6 or 7	1 receiver every 5 years	G6: 1 transmitter every 90 days G7: NA	1 sensor every 10 days
Freestyle Libre	1 reader every 5 years	NA	1 sensor every 14 days

*Receivers and readers may not be needed if the member is able to use a compatible smartphone

Approval Criteria		
1. What diagnosis is being treated?	Record ICD10 code.	
2. Is the request for diabetic supplies in excess of amounts outlined in Table 1?	**Yes:** Pass to RPh. Deny; DME in excess of quantity limit.	**No:** Go to #3
3. Is the request for continuation of therapy previously approved by FFS?	**Yes:** Go to **Renewal Criteria**	**No:** Go to #4
4. Has the patient received (or will receive) diabetes education specific to the use of CGM?	**Yes:** Go to #5 Document provider attestation	**No:** Pass to RPh. Deny; medical appropriateness
5. Is the request for type 1 diabetes mellitus?	**Yes**: Go to #6	**No:** Go to #7

Approval Criteria		
6. Is there documentation for any of the following: a. age of 21 years or less b. current pregnancy or plans to become pregnant within 6 months c. current use of an insulin pump d. HbA1c ≥ 8.0% (in the past 3 months or prior to CGM use) OR e. Frequent, severe, or impaired awareness of hypoglycemia	**Yes:** Go to #9	**No:** Pass to RPh. Deny; medical appropriateness
7. Is the request for gestational or type 2 diabetes AND is the patient using short or intermediate acting insulin?	**Yes:** Go to #8	**No:** Pass to RPh. Deny; medical appropriateness
8. Is there documentation for any of the following: a. HbA1c ≥ 8% (in the past 3 months or prior to CGM use) b. Frequent, severe, or impaired awareness of hypoglycemia OR c. Diabetes-related complications (e.g., peripheral neuropathy, cardiovascular disease, end-organ damage, etc)	**Yes:** Go to #9	**No:** Pass to RPh. Deny; medical appropriateness
9. Is the request for a cost-effective product OR will the prescriber switch to a cost-effective product (Table 1)?	**Yes:** Approve necessary supplies for the preferred product for 6 months or for the duration of the pregnancy (up to 12 months)	**No:** Pass to RPh. Deny; cost-effectiveness for DME.

Renewal Criteria		
1. Is the request for continuation of CGM *after* a pregnancy?	**Yes:** Go to #2	**No:** Go to #3
2. Does the patient meet any other criteria for approval? Note: continuation after a pregnancy is only considered medically appropriate for members who meet other criteria for approval (see above).	**Yes:** Go to #3	**No:** Pass to RPh. Deny; medical appropriateness

Renewal Criteria		
3. Has the member used the device for at least 50% of the time at their first follow-up visit?	**Yes:** Approve for 12 months Document use based on CGM metrics	**No:** Pass to RPh. Deny; medical appropriateness

Implementation: 1/1/24