

# Continuous Monitoring of Glucose in the Interstitial Fluid Prior Review Fax Form

PRESCRIBER INFORMATION		PATIENT INFORMATION	
PHYSICIAN NAME	PROVIDER ID/TAX ID (if out of state must have tax ID)	PATIENT NAME	
CONTACT PERSON/PRACTICE NAME		PATIENT'S BCBSNC ID	
PRACTICE PHONE	PRACTICE FAX	PATIENT'S DATE OF BIRTH	
PRACTICE ADDRESS	CITY	STATE	ZIP

**Servicing Provider:** \_\_\_\_\_ **Phone** \_\_\_\_\_ **Fax** \_\_\_\_\_  
**HCPCS Code:** \_\_\_95250; \_\_\_95251; \_\_\_99091; \_\_\_A9276; \_\_\_A9277; \_\_\_A9278; \_\_\_S1030; \_\_\_S1031  
**Diagnosis Code:** \_\_\_\_\_

**1. Does the patient have Type 1 Diabetes, perform finger sticks at least 4x/day, AND use an insulin pump?** \_\_\_  
 \_\_\_ Yes \_\_\_ No

**2. Intermittent monitoring (72 hours) of glucose levels in interstitial fluid:**  
 Does the patient have poorly controlled Type I diabetes,\* as documented by the following: (choose all that apply)  
 \_\_\_ Hemoglobin A1C not in acceptable target range for the patient's clinical situation  
 \_\_\_ Unexplained hypoglycemic episodes  
 \_\_\_ Hypoglycemic unawareness  
 \_\_\_ Suspected postprandial hyperglycemia  
 \_\_\_ Recurrent diabetic ketoacidosis

Is the intermittent monitoring requested to determine basal insulin levels prior to insulin pump initiation? \_\_\_ Yes \_\_\_ No

Does the patient have poorly controlled Type I diabetes,\* and is pregnant or about to become pregnant? \_\_\_ Yes \_\_\_ No

**3. Continuous monitoring of glucose levels in interstitial fluid, including real-time monitoring:**  
**Was a 72hr glucose monitor previously used?** \_\_\_ Yes \_\_\_ No

Does the patient have Type I diabetes with recurrent unexplained, severe, symptomatic hypoglycemia (generally blood glucose levels less than 50 mg/dl), for whom hypoglycemia puts the patient or others at risk?  
 \_\_\_ Yes \_\_\_ No

Does the patient have poorly controlled Type I diabetes\* and is pregnant?  
 \_\_\_ Yes \_\_\_ No

\*(Poorly controlled Type I diabetes includes unexplained hypoglycemic episodes, hypoglycemic unawareness, suspected postprandial hyperglycemia, or recurrent diabetic ketoacidosis, despite current use of best practices.)  
 Effective: 5/1/2011

**PHYSICIAN ATTESTATION:** By signing below, I certify that I have been authorized to request prior review and certification for the above requested service(s). I further certify that my patient's medical records accurately reflect the information provided. I understand that BCBSNC may request medical records for this patient at any time in order to verify this information. I further understand that if BCBSNC determines this information is not reflected in my patient's medical records, BCBSNC may request a refund of any payments made and/or pursue any other remedies available.

**Please certify the following by signing and dating below:**

\*Physician signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 (\*Original Physician signature required. Stamped signatures not acceptable)

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