DisclosedRx
The Fiduciary and Fully Disclosed PBM®

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Prior Authorization Request Form

Continuous Glucose Monitoring (CGM) Systems

☐ Standard ☐ Urgent ☐ Reconsideration/Appeal

Patient Information

Patient Name: _____ DOB (mm/dd/yyyy): _____ Gender: _____

Address: _____ City: _____ State & Zip: _____

Cardholder ID: _____ Group #: _____ Relationship Code: _____

Phone Number: _____ Email address: _____

Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Address: _____ City: _____ State & Zip: _____

Office Contact: _____ Phone Number: _____ Fax Number: _____

Medication Information

Drug Name: _____ Strength: _____ Quantity: _____

Directions: _____ Day Supply: _____

Indicate Request Type: ☐ New Start ☐ Renewal Therapy Start Date (if applicable): _____

Diagnosis: _____ ICD 10 Code: _____

Prior Authorization Request Information

Supporting documentation (i.e., chart notes, labs, etc.) must be attached to avoid processing delays

1. Does the patient have any FDA contraindications to the requested agent? ☐Yes ☐No
2. Is the patient currently taking an insulin product (i.e., rapid, short, or long-acting insulin)? If yes, please list below & provide documentation. ☐Yes ☐No

Drug Name/Strength:	Start Date:	End Date:	Outcome:

Prescriber Signature: _____ Date: _____

Authorized Agent's Name: _____

Please fax this request to 602-585-0588 or our secure email at care@disclosedrx.com
Mail Requests to: DisclosedRx Clinical Team
PO Box 701 Washington, IN 47501

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