DisclosedRx
The Fiduciary and Fully Disclosed PBM®

PO Box 35
Trexlertown, PA 18087-0035
Phone: 480-561-6005
Fax: 602-669-1169

Prior Authorization Request Form

Continuous Glucose Monitoring (CGM) Systems

☐ Standard ☐ Urgent

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 602-669-1169 or our secure email at PriorAuthorizations@disclosedrx.com

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