DO NOT WRITE IN THIS SPACE

DEXCOM G6 CONTINUOUS GLUCOSE MONITORING (CGM) INITIAL/RENEWAL REQUEST FORM

Mail: PO Box 7000, Vancouver, BC V6B 4E1 | Drop it off: 4250 Canada Way, Burnaby, BC | Fax: 604 419-2689 | Toll-free fax: 1 844 419-2689 | pac.bluecross.ca

HOW TO COMPLETE THIS FORM:
PLAN MEMBERS — Please complete RED portions of this form.
PHYSICIANS — Please complete BLACK portions of this form.

Don't forget to sign *Part 6 — Member Consent and Declaration* before you submit your claim.

The patient is responsible for any fees charged by the physician for completion of this form. These fees are not eligible for reimbursement under your Pacific Blue Cross Extended Health Care plan.

Completion of this form does NOT imply approval for a CGM device or supplies. CGM coverage is not available under all Pacific Blue Cross plans. Coverage is based on the provisions of your Extended Health Care plan and Pacific Blue Cross qualification criteria.

PART 1 — PLAN MEMBER TO COMPLETE

Plan member's name	Patient's name (if different than Plan member's name)

Patient's birthdate (mm-dd-yyyy)	Patient's weight	Patient's height	Policy number	ID number	☐ Other insurance coverage

Street address	City	Province	Postal code	Daytime phone number (10 digits)

☐ I am aware that if I choose to use the Dexcom G6 Continuous Glucose Monitoring system I will be limited to a maximum of 200 test strips per calendar year during the time I am using this system.

PART 2 — PHYSICIAN WHO IS MANAGING THE CGM TO COMPLETE

Physician's name	College ID

Street address	City	Province	Postal code

Physician's area of specialty: ☐ Endocrinologist ☐ Diabetes specialist ☐ Internal medicine ☐ Other: ____________________

I certify that the medical information provided is accurate and current:

Physician's signature	Date (mm-dd-yyyy)
X	

PART 3 — INITIAL REQUEST (1 YEAR)

In order to be considered for Dexcom G6 CGM, **ALL** of the following must apply:

☐ Patient is 2 years of age or older with diabetes mellitus (DM)
☐ Patient is receiving intensive insulin therapy through
  ☐ multiple daily injections of insulin (basal plus bolus combination therapy) **OR**
  ☐ currently receiving insulin via an insulin pump
☐ Patient/family/caregiver agrees to comprehensive and age-appropriate diabetes education by an interdisciplinary diabetes healthcare team and commits to regular follow-up

AND, patient has at least one of the following:

☐ Hypoglycemia unawareness
☐ Frequent and unpredictable hypoglycemic episodes
☐ Unpredictable swings in blood glucose
☐ At least one functional restriction that inhibits the use of blood glucose test strips
☐ An occupation where hypoglycemia presents a significant safety risk

PART 4 — RENEWAL REQUEST (5 YEARS)

In order to be considered for renewal of coverage for Dexcom G6 CGM, **ALL** of the following must apply:

☐ The patient with diabetes mellitus (DM) continues to require intensive insulin therapy through
  ☐ multiple daily injections of insulin, **OR**
  ☐ insulin pump
☐ The patient will benefit from continued use of a Dexcom G6 CGM

PART 5 — ADDITIONAL INFORMATION

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PART 6 — MEMBER CONSENT AND DECLARATION

IMPORTANT: This section must be signed before submitting your form.

I declare that all information in this form is true and complete. I understand Pacific Blue Cross will use the personal information on this form, and any other personal information they hold about me and my eligible dependents to determine eligibility for benefits and pay claims.

I acknowledge and agree that personal information about me and my eligible dependents may be collected, used and exchanged between Pacific Blue Cross and any other person or organization related to this claim or the administration of my benefit plan. This includes health care professionals, institutions, investigative agencies, insurers/re-insurers, government organizations or regulatory bodies. I acknowledge disclosure of my personal information by Pacific Blue Cross to my plan sponsor when required or permitted by law or pursuant to its contractual obligations under my benefit plan. I understand I may revoke this consent at any time and acknowledge that should I do so, this claim may not be considered.

If there is overpayment, I authorize its recovery from any amount payable to me under my benefit plan(s).

I have read and understand this Member Consent and Declaration and agree that a photocopy or digital version shall be as valid as the original and may remain in effect for the continued administration of this plan. I authorize my physician to release my personal information to Pacific Blue Cross to obtain approval for prescription benefit.

Member's signature	Date (mm-dd-yyyy)
X	

MAIL YOUR FORM
Pacific Blue Cross
PO Box 7000, Vancouver, BC V6B 4E1

DROP IT OFF
4250 Canada Way
Burnaby, BC V5G 4W6

FAX IT
604 419-2689
Toll-free: 1 844 419-2689

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