Pennsylvania
Department of Human Services

Medical Assistance BULLETIN

ISSUE DATE	EFFECTIVE DATE	NUMBER
November 7, 2025	January 5, 2026	*See below

SUBJECT

Prior Authorization of Continuous Glucose Monitoring Products – Pharmacy Services

BY

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Deputy Secretary
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IMPORTANT REMINDER: All providers must revalidate the Medical Assistance (MA) enrollment of each service location every 5 years. Providers should log into PROMISe to check the revalidation dates of each service location and submit revalidation applications at least 60 days prior to the revalidation dates. Enrollment (revalidation) applications may be found at: https://www.pa.gov/en/agencies/dhs/resources/for-providers/provider-enrollment-information/provider-enrollment-documents.html.

PURPOSE:

The purpose of this bulletin is to issue updated handbook pages that include the requirements for prior authorization and the type of information needed to evaluate the medical necessity of prescriptions for Continuous Glucose Monitoring Products submitted for prior authorization.

SCOPE:

This bulletin applies to all licensed pharmacies and prescribers enrolled in the Medical Assistance (MA) Program. The guidelines to determine the medical necessity of Continuous Glucose Monitoring Products will be utilized in the fee-for-service and managed care delivery systems. Providers rendering services to MA beneficiaries in the managed care delivery system should address any questions related to the prior authorization of Continuous Glucose Monitoring Products to the appropriate managed care organization.

BACKGROUND/DISCUSSION:

The Department of Human Services (Department) is updating the medical necessity guidelines for a non-preferred Continuous Glucose Monitoring Product to allow for approval

*01-26-13	09-26-13	27-26-13	33-26-13
02-26-13	11-26-13	30-26-13	
03-26-13	14-26-13	31-26-13	
08-26-13	24-26-13	32-26-13	

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Fee-for-Service Provider Service Center: 1-800-537-8862

Visit the Office of Medical Assistance Programs website at:
https://www.pa.gov/en/agencies/dhs/departments-offices/omap-info.html

based on compatibility with a beneficiary's insulin delivery device. There are no other changes to the medical necessity guidelines.

The revisions to the guidelines to determine medical necessity of prescriptions for Continuous Glucose Monitoring Products were subject to public review and comment and subsequently approved for implementation by the Department.

PROCEDURE:

The procedures for prescribers to request prior authorization of Continuous Glucose Monitoring Products are located in SECTION I of the Prior Authorization of Pharmaceutical Services Handbook. The Department will take into account the elements specified in the clinical review guidelines (which are included in the provider handbook pages in the SECTION II chapter related to Continuous Glucose Monitoring Products) when reviewing the prior authorization request to determine medical necessity.

As set forth in 55 Pa. Code § 1101.67(a), the procedures described in the handbook pages must be followed to ensure appropriate and timely processing of prior authorization requests for drugs and products that require prior authorization.

ATTACHMENTS:

Prior Authorization of Pharmaceutical Services Handbook - Updated pages

RESOURCES:

Prior Authorization of Pharmaceutical Services Handbook – SECTION I
Pharmacy Prior Authorization General Requirements
https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/pharmacy-prior-authorization-general-requirements.html

Prior Authorization of Pharmaceutical Services Handbook – SECTION II
Pharmacy Prior Authorization Guidelines
https://www.pa.gov/en/agencies/dhs/resources/pharmacy-services/clinical-guidelines.html

I. Requirements for Prior Authorization of Continuous Glucose Monitoring Products

A. Prescriptions That Require Prior Authorization

All prescriptions for Continuous Glucose Monitoring Products must be prior authorized.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for a Continuous Glucose Monitoring Product, the determination of whether the requested prescription is medically necessary will take into account whether the beneficiary:

1. Has **one** of the following:

   a. Use of an antidiabetic medication within the last 90 days
   b. A diagnosis of diabetes;

   AND

2. For a non-preferred Continuous Glucose Monitoring Product, **one** of the following:

   a. Has a history of therapeutic failure of the preferred Continuous Glucose Monitoring Products
   b. Requires a non-preferred Continuous Glucose Monitoring Product for compatibility with their insulin delivery device

   See the Preferred Drug List for the list of preferred Continuous Glucose Monitoring Products at: https://papdl.com/preferred-drug-list;

   AND

3. If a prescription for a Continuous Glucose Monitoring Product is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in the Quantity Limits Chapter. The list of drugs/products that are subject to quantity limits, with accompanying quantity limits, is available at: https://www.pa.gov/agencies/dhs/resources/pharmacy-services/quantity-limits-daily-dose-limits.

   NOTE: If the beneficiary does not meet the clinical review guidelines listed above but, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a Continuous Glucose Monitoring Product. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the beneficiary.

D. Dose and Duration of Therapy

Approvals of requests for prior authorization of prescriptions for Continuous Glucose Monitoring Products will be approved for 12 months.

E. References

1. Clinical Resource, Continuous Glucose Monitoring. Pharmacist's Letter/Pharmacy Technician's Letter/Prescriber's Letter. May 2023. [390502]
2. ElSayed NA, Aleppo G, Aroda VR, et al. 7. Diabetes Technology: Standards of Care in Diabetes-2023. Diabetes Care. 2023 Jan 1;46(Suppl 1):S111-S127
3. Allen NA, Fain JA, Braun B, et al. Continuous glucose monitoring in non-insulin-using individuals with type 2 diabetes: acceptability, feasibility, and teaching opportunities. Diabetes Technol Ther. 2009 Mar;11(3):151-8. doi: 10.1089/dia.2008.0053.
4. Dowd R, Jepson LH, Green CR, et al. Glycemic Outcomes and Feature Set Engagement Among Real-Time Continuous Glucose Monitoring Users With Type 1 or Non-Insulin-Treated Type 2 Diabetes: Retrospective Analysis of Real-World Data. JMIR Diabetes. 2023 Jan 18;8:e43991. doi: 10.2196/43991.