Clinical Policy: Non-Preferred Blood Glucose Monitors/Test Strips

Reference Number: CP.PMN.215
Effective Date: 12.01.19
Last Review Date: 11.24
Line of Business: Medicaid

Revision Log

See Important Reminder at the end of this policy for important regulatory and legal information.

Description
Blood glucose monitors and test strips are used together to monitor blood glucose levels. Prior authorization is required for non-preferred blood glucose monitors and test strips.

If request is for a continuous glucose monitor, refer to CP.PMN.214 Continuous Glucose Monitors.

FDA Approved Indication(s)
Blood glucose monitors and test strips are indicated for use in patients with diabetes mellitus to monitor blood glucose levels.

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of health plans affiliated with Centene Corporation® that non-preferred blood glucose monitors and test strips are **medically necessary** when the following criteria are met:

I. Initial Approval Criteria

A. Request for Non-Preferred Blood Glucose Monitors/Test Strips (must meet all)**:**

If request is for a continuous glucose monitor, refer to CP.PMN.214 Continuous Glucose Monitors.

1. Documentation supports inability to use the health-plan preferred blood glucose monitor(s) and/or test strip(s) – examples include, but are not limited to, any of the following:
   a. Member has impaired vision and requires a blood glucose monitor with audio;
   b. Member has limited dexterity (e.g., arthritis) and requires larger test strips, a blood glucose monitor with larger buttons, or pre-loaded lancet drum with no individual lancets;
   c. Member is currently using an insulin pump that is incompatible with the preferred products;
2. Requested quantity does not exceed the health-plan quantity limit (if applicable).

Approval duration: 12 months

II. Continued Therapy: Not applicable

III. Diagnoses/Indications for which coverage is NOT authorized: Not applicable

IV. Appendices/General Information

Appendix A: Abbreviation/Acronym Key
CGM: continuous glucose monitoring
FDA: Food and Drug Administration
SMBG: self-monitoring of blood glucose

Appendix B: Therapeutic Alternatives
This table provides a listing of preferred alternative products recommended in the approval criteria. The products listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.

Product Name	Dosing Regimen	Dose Limit/ Maximum Dose
FreeStyle® products: FreeStyle Lite, FreeStyle Freedom Lite, Precision Xtra®	Varies	Not applicable
OneTouch® products: OneTouch Verio® Flex, OneTouch Delica® Plus	Varies	Not applicable

Appendix C: Contraindications/Boxed Warnings
None reported

Appendix D: General Information
- Blood glucose monitoring (either with self-monitoring [SMBG] or continuous monitoring [CGM]) is a tool used to evaluate whether glycemic targets are being achieved. It enables evaluation of response to both pharmacologic therapy and lifestyle modifications and can therefore help guide treatment decisions and/or self-management.
- The American Diabetes Association and American Association of Clinical Endocrinologists do not prefer any one blood glucose monitor/test strip brand over another. The choice of device should be made on the individual's circumstance, preferences, and needs.

V. Dosage and Administration

Usage regimen is individualized based on patient goals.

VI. Product Availability

Monitor and test strip packaging vary by product and manufacturer.

VII. References

1. American Diabetes Association. Standards of medical care in diabetes—2024. Diabetes Care. 2024; 47(suppl 1): S1-S322. Accessed July 30, 2024.
2. Samson SL, Vellanki P, Blonde L, et al. American Association of Clinical Endocrinology Consensus statement: Comprehensive type 2 diabetes management algorithm - 2023 update. Endocr Pract. 2023 May;29(5):305-340. doi: 10.1016/j.eprac.2023.02.001.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
4Q 2020 annual review: no significant changes; references reviewed and updated.	07.01.20	11.20
4Q 2021 annual review: no significant changes; references reviewed and updated.	06.28.21	11.21
Per November SDC, added requirement that requested quantity does not exceed the health-plan quantity limit (if applicable); removed Trividia from Appendix B.	11.30.21	02.22
4Q 2022 annual review: no significant changes; references reviewed and updated.	07.18.22	11.22
4Q 2023 annual review: no significant changes; references reviewed and updated.	08.07.23	11.23
4Q 2024 annual review: no significant changes; references reviewed and updated.	07.30.24	11.24

Important Reminder
This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. "Health Plan" means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan's affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions, and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment, or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members, and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

Note:
For Medicaid members, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.