Pharmacy Medical Necessity Guidelines:
Continuous Glucose Monitoring Systems – Dexcom G6 and G7 Systems

Effective: January 13, 2026

Prior Authorization Required	√	Type of Review – Care Management	
Not Covered		Type of Review – Clinical Review	√
Pharmacy (RX) or Medical (MED) Benefit	RX	Department to Review	RxUM
These pharmacy medical necessity guidelines apply to the following: ☒ Tufts Health RITogether – A Rhode Island Medicaid Plan		**Fax Numbers:** RXUM: 617.673.0939	

Note: This guideline does not apply to Medicare Members (includes dual eligible Members).

OVERVIEW

The pancreas is an organ in the body that secretes several hormones, including insulin and glucagon, as well as digestive enzymes that help break down food. Insulin is a hormone that the body needs to get glucose, which it uses for energy, from the bloodstream into the cells of the body. Diabetes (diabetes mellitus) is a condition of impaired insulin production and variable degrees of insulin resistance, leading to hyperglycemia (high levels of glucose in the bloodstream). Type 1 diabetes occurs when the pancreas produces little or none of the insulin needed to regulate blood glucose. Type 2 diabetes occurs when the pancreas does not produce enough insulin or the body becomes resistant to the insulin that is present.

The goal of treatment for diabetes regardless of the type is to keep blood glucose levels within a target range. Poorly controlled glucose levels can lead to numerous acute and chronic complications, some of which can be life threatening. Continuous glucose monitoring systems (CGMS) are minimally invasive or noninvasive devices that measure glucose levels in interstitial fluid at frequent intervals. CGMS are designed to obtain information regarding diurnal patterns in glucose levels that, when evaluated in real time or reviewed retrospectively by a physician, can guide adjustments to therapy, with the goal of improving overall glycemic control.

COVERAGE GUIDELINES

Tufts Health Plan may authorize the coverage of a personal, long-term continuous glucose monitoring system (CGMS) to be used by a member when the following criteria are met:

Initial

1) The Member has type 1 diabetes

OR

2) The Member has type 2 diabetes and meets ONE of the following:
   a) Requires insulin administration in addition to other medication
   b) Despite being compliant with prescribed treatment has ONE of the following:
      i) Poorly controlled A1C
      ii) Unexplained hypoglycemic episodes
      iii) Hypoglycemic unawareness
      iv) Suspected postprandial hyperglycemia
      v) Recurrent diabetic ketoacidosis

OR

3) The Member has a diagnosis of gestational diabetes

Reauthorization

1) Documentation from the provider that the CGM is medically necessary

AND

2) Documentation from the provider that the Member continues to use the CGM

Replacement

Tufts Health Plan may authorize replacement of a continuous glucose monitoring system when documentation confirms that the device is five years old or older, OR that **ALL** of the following are met:

1. The above criteria are met and the device is malfunctioning and out of warranty

AND

2. Documentation the provider has assessed the individual and recommends continued use of the CGM

LIMITATIONS

- Any requests for non-covered Continuous Glucose Monitors and related supplies, such as Freestyle Libre, Medtronic Guardian, Dexcom 4 and Dexcom 5, will require detailed clinical documentation of

need for alternative treatment and will be considered on a case-by-case basis. Refer to the Pharmacy Medical Necessity Guidelines for Pharmacy Products Without Specific Criteria and submit a formulary exception request to Tufts Health Plan, as indicated.

- Tufts Health Plan will only allow access to continuous glucose monitoring systems at pharmacies:
  - All other Artificial Pancreas Device Systems (APDS) should be reviewed by Precertification/Medical Management and may be covered under the medical benefit if approved
- CGMs that are only interpreted in a provider's office (e.g., FreeStyle Libre Pro) are not covered under the pharmacy benefit.
- Approval lengths are as follows:
  - Type 1 Diabetes, Type 2 Diabetes: 1 year
  - Gestational Diabetes: 9 months
- Limitations on approvals are as follows:

Description	NDC	Refills
Dexcom G6 Receiver (Retail)	08627-0091-11	1 receiver per 365 days
Dexcom G6 Transmitter (Retail)	08627-0016-01	1 transmitter every 90 days
Dexcom G6 Sensor Pack (Retail)	08627-0053-03	1 sensor pack (3 sensors) every 30 days
Dexcom G7 Receiver (Retail)	08627-0077-01	1 receiver per 365 days
Dexcom G7 Sensor (Retail)	08627-0078-01	1 sensor pack (3 sensors) every 30 days
Dexcom G7 15 Day Sensor (Retail)	08627-0079-01	1 sensor pack (2 sensors) every 30 days

CODES

None

REFERENCES

1. Hayes, Winifred S. Directory Report. Continuous Glucose Monitoring Systems. August 13, 2015. Annual review: July 26, 2017. Available at hayesinc.com. Last accessed February 8, 2018.
2. American Diabetes Association. Standards of Medical Care in Diabetes-2024. *Diabetes Care.* 2024;47(Suppl 1):S1-S321.
3. American Diabetes Association. Diabetes Basics. Available at diabetes.org. Last accessed June 5, 2017.

APPROVAL HISTORY

September 13, 2022: Reviewed by Pharmacy and Therapeutics Committee.

Subsequent endorsement date(s) and changes made:

1. January 10, 2023: Effective January 16, 2023, updated criteria to include approval for type 2 diabetes, and gestational diabetes. Updated criteria for type 1 diabetes to require diagnosis.
2. March 14, 2023: Effective March 20, 2023, added Dexcom G7 to the MNG.
3. January 9, 2024: Effective February 1, 2024, updated fax number for RxUM.
4. January 14, 2025: No changes
5. January 13, 2026: Effective January 13, 2026, added Dexcom G7 15 Day sensor to MNG.

BACKGROUND, PRODUCT AND DISCLAIMER INFORMATION

Pharmacy Medical Necessity Guidelines have been developed for determining coverage for plan benefits and are published to provide a better understanding of the basis upon which coverage decisions are made. The plan makes coverage decisions on a case-by-case basis considering the individual member's health care needs. Pharmacy Medical Necessity Guidelines are developed for selected therapeutic classes or drugs found to be safe, but proven to be effective in a limited, defined population of patients or clinical circumstances. They include concise clinical coverage criteria based on current literature review, consultation with practicing physicians in the service area who are medical experts in the particular field, FDA and other government agency policies, and standards adopted by national accreditation organizations. The plan revises and updates Pharmacy Medical Necessity Guidelines annually, or more frequently if new evidence becomes available that suggests needed revisions.

For self-insured plans, coverage may vary depending on the terms of the benefit document. If a discrepancy exists between a Pharmacy Medical Necessity Guideline and a self-insured Member's benefit document, the provisions of the benefit document will govern.

Treating providers are solely responsible for the medical advice and treatment of members. The use of this policy is not a guarantee of payment or a final prediction of how specific claim(s) will be adjudicated. Claims payment is subject to member eligibility and benefits on the date of service, coordination of benefits, referral/authorization and utilization management guidelines when applicable, and adherence to plan policies and procedures and claims editing logic.

Provider Services