**Request to be considered for funding of Flash Glucose Monitoring**

**Introduction**

Flash Glucose testing e.g.FreeStyle Libre® is a grey listed product within Stockport and requires prior approval from the CCG. In order to receive funding for this device a patient must meet the criteria given in the GMMMG position statement or the national funding guidance which states the device will only be funded for:

1. People with Type 1 diabetes

OR with any form of diabetes on haemodialysis and on insulin treatment who, in either of the above, are clinically indicated as requiring intensive monitoring >8 times daily, as demonstrated on a **meter download or meter review** over the **past 3 months**.

NB Please note a statement of testing more than 8 times a day is not sufficient. This must be validated by evidence.

OR with diabetes associated with cystic fibrosis on insulin treatment

1. Pregnant women with Type 1 Diabetes - Maximum12 months in total inclusive of post-delivery period. No approval is required if patient is already pregnant. NB GMMMG permits preconception use but this does require approval.
2. People with Type 1 diabetes unable to routinely self-monitor blood glucose due to disability who require carers to support glucose monitoring and insulin management.
3. People with Type 1 diabetes for whom the specialist diabetes MDT determines have occupational (e.g. working in insufficiently hygienic conditions to safely facilitate finger-prick testing) or psychosocial circumstances that warrant a 6-month trial of Libre®, with appropriate adjunct support. This must be a defined risk that cannot be mitigated by other action.
4. Previous self-funders of Flash Glucose Monitors with Type 1 diabetes where those with clinical responsibility for their diabetes care are satisfied that their clinical history suggests that they would have satisfied one or more of these criteria prior to them commencing use of Flash Glucose Monitoring had these criteria been in place prior to April 2019 **AND** has shown sustained improvement in HbA1c since self-funding.
5. For those with Type 1 diabetes and recurrent severe hypoglycaemia or impaired awareness of hypoglycaemia, NICE suggests that Continuous Glucose Monitoring with an alarm is the standard. Other evidence-based alternatives with NICE guidance or NICE TA support are pump therapy, psychological support, structured education, islet transplantation and whole pancreas transplantation. However, if the person with diabetes and their clinician consider that a Flash Glucose Monitoring system would be more appropriate for the individual’s specific situation, then this can be considered.

Full details of alternatives considered and rejected must be provided.

Further detail is available on the GMMMG website at <http://gmmmg.nhs.uk/docs/nts/FreeStyle-Libre-revised-recommendation-07-19.pdf>

Prescribing will not usually be commenced in primary care as the patient requires training and support from the specialist service. Please ensure your patient will have the required support or if they have previously self-funded that they are competent in the use of the device.

Patients must agree to certain basic requirements before approval will be considered.

The patient should be asked to sign a contract to agree to meet the requirements of provision. Failure to comply with these requirements may result in funding being withdrawn.

**Confidentiality for approval request**

**Patient identifiable information should not be included unless specific patient consent has been obtained and documented on the form and in the clinical record.**

Any materials received which include patient identifiable information without consent to share with the panel will be rejected, deleted and the practice notified.

**Process to request prior approval**

This pro-forma is designed to facilitate the full and fair consideration of each request. All sections should be completed in respect of each patient for whom such a request is made. It is your responsibility to provide information to demonstrate that the patient meets the necessary criteria. Any form which is not adequately completed will be sent back to the requestor.

The information will be reviewed at the earliest opportunity and a response is usually provided within 10-15 working days

**Please email the completed request and all supporting documentation to**

[STOCCG.medsopadmin@nhs.net](mailto:STOCCG.medsopadmin@nhs.net)

These guidance pages do not need to be sent with your request.

|  |  |  |
| --- | --- | --- |
| **Request for prior approval to fund Flash Glucose Monitoring**  If you have any queries please contact the Medicines Optimisation Team via the admin team **STOCCG.medsopadmin@nhs.net or by phone on** 0161 426 9910  Any form received which lacks patient consent will be destroyed and the practice notified unless fully anonymised.  All fields are mandatory | | |
|  | ***Is the patient aware of this request and have they consented to the information being shared.*** | (*any form without clear confirmation that consent* ***was*** *given will be destroyed & the practice notified)* |
| **A** | Patients’ NHS number  *(Forms will be returned if not included)* |  |
| **B** | Patients’ GP Clinical System Number *(as 2nd identifier)* |  |
| **C** | Age if clinically relevant |  |
| **C** | GP Practice Details | Practice Name |
| **D** | Referring clinician Name and Nhs.net e-mail addresses for response | @nhs.net |
| **E** | Confirm patient has type 1 diabetes  Is the patient currently under a specialist service?  If so who and where?  Did the consultant suggest the patient have access to flash glucose monitoring?  Other clinically relevant conditions or therapies e.g. cystic Fibrosis or haemodialysis | YES / NO  YES / NO  Consultant  Hospital  YES / NO |
| **F** | Has the patient agreed to:  Scan levels at least 8 times a day  Use the sensor for >70% of tests  Agreed to regular reviews  If any response is no please give justification. | YES / NO  YES / NO  YES / NO |
| **G** | *Has the patient previously completed a structured education program?*  *If no*  *Has the patient agreed to attend one within the 3-6 month trial* | Date attended  Type of course  YES / NO |
| **H** | Clearly indicate which nationally specified criteria are met (see page 1 introduction for details). More than one criterion may apply. | 1 / 2 / 3 / 4 / 5 / 6 |
|  | Provide evidence of the criteria being met | *Please complete full details for the applicable criteria only to avoid the approval of your request being delayed or rejected* |
| **1** | *Criteria 1*  *Please provide details of*  *Time period of data reviewed.( min 4 weeks )*  *Average no of tests daily*  *Date of meter download/ review*  *What strips are used*  *Does the patient purchase additional strips for testing*  *Issue history over* ***at least*** *the last 3 months. (This will be requested if not provided)* | E.g. Accucheck Performa  Give date and quantity of each issue |
| **2** | *Criteria 2*  *(these individuals would normally already be under the specialist service)*  Type of diabetes | Trying to conceive/ pregnant  Due date (where known)  Type 1 Diabetes / Type 2 diabetes on basal bolus regime |
| **3** | *Criteria 3*  *Please give details of the disability the means the individual cannot test conventionally, who provides the care and what diabetes care is provided other than testing, Clinicians should verify the veracity of this statement* |  |
| **4** | *Criteria 4*  *Please give details of the type of work undertaken and why finger pricking would be unsafe.*  *AND/ OR*  *Give details of psychosocial situation that warrant a trial. See GMMMG statement for more information*  *What support has been accessed to mitigate this?*  *Please give full details and any relevant supporting letters that support this.* |  |
| **13** | *Criteria 5*  *Date first self-funded*  *Last HbA1c before this and the date of test.*  Which criteria would they have been eligible under prior to self-funding  NB that criteria box must also be completed as if applying at that time | Month Year  Mm/l Date  1 / 2 / 3 / 4 / 6 |
| **14** | *Criteria 6*  *Please give detail of reason Flash testing is advocated*  *E.g. levels of hypo-awareness historically and when changes occurred.Impact of hypoglycaemia ( NICE TA 151)*  *What alternatives to flash glucose testing have been considered e.g. continuous glucose monitoring,*  *Why have these options not been used?*  Please give full details of consideration for *pump therapy, psychological support, structured education, islet transplantation and whole pancreas transplantation.* | Level of awareness historically  Level of awareness currently  Score  Date of change |
| **15** | *Please provide the 4 most recent HbA1c levels and the dates of these results* | Mm/l Date  Mm/l Date  Mm/l Date  Mm/l Date |
| **16** | *Is the individual fully complaint with therapy and dietary measures* | Yes / No |
| Signature of referring clinician:  Print Name  Date | |  |
| Comments | | |

**FOR MO USE ONLY**

|  |  |  |
| --- | --- | --- |
| Date request received Case No | | |
| Added to database | | |
| Triage under framework completed by Date | | |
| Outcome *(delete as appropriate)*  Passed back as inadequate detail / Rejected / Approved  For panel | | |
| Reviewer Comments | | |
| Action |  | Received |
| Date for audit |  |  |
| Network Lead informed. |  |  |