



## Drug Coverage Policy

Effective Date .....11/1/2025

Coverage Policy Number.....IP0272

Policy Title.....Diabetic Supplies

# Diabetes – Diabetic Supplies

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### **INSTRUCTIONS FOR USE**

*The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Each coverage request should be reviewed on its own merits. Medical directors are expected to exercise clinical judgment where appropriate and have discretion in making individual coverage determinations. Where coverage for care or services does not depend on specific circumstances, reimbursement will only be provided if a requested service(s) is submitted in accordance with the relevant criteria outlined in the applicable Coverage Policy, including covered diagnosis and/or procedure code(s). Reimbursement is not allowed for services when billed for conditions or diagnoses that are not covered under this Coverage Policy (see "Coding Information" below). When billing, providers must use the most appropriate codes as of the effective date of the submission. Claims submitted for services that are not accompanied by covered code(s) under the applicable Coverage Policy will be denied as not covered. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.*

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### **Overview**

There are a variety of blood glucose meters available on the market with varying features. However, most meters generally offer a small sample size, the ability to test at alternate sites (besides the fingertips) and have easily readable screens. For visually impaired patients, speaking meters are available from select manufacturers. There are a small number of blood glucose meters that interact wirelessly with a specific insulin pump providing data for basal and bolus

insulin needs based on the blood glucose measurement. Various sources, including device manufacturers and the American Diabetes Association (ADA), maintain updated lists of available products, including their features and compatibility.<sup>1-7</sup>

Diabetic test strips are measured for accuracy using standards set forth by the International Organization for Standardization and/or FDA.<sup>8-10</sup> Currently marketed monitors must meet the standard under which they were approved.<sup>1</sup> The ADA Standards of Care (2023) acknowledge that monitoring of accuracy is left to the manufacturer and is not routinely checked by an independent source; there may be variation in accuracy of blood glucose monitoring systems. However, a preference is not made in the ADA Standards for any particular brand of test strip over others.

## Coverage Policy

Coverage criteria are listed for products **in below table**:

### Employer Plans:

| Product                                       | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |
|-----------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Glucose Test Strips</b><br>(non-formulary) | <p><b><u>Legacy:</u></b><br/> <b>Glucose Test Strips (non-formulary)</b> are considered medically necessary when <b>ONE</b> of the following is met (1 <u>or</u> 2):</p> <ol style="list-style-type: none"> <li>1. Patient has tried <b>ONE</b> of the following (A, B, C, D, <u>or</u> E): <ul style="list-style-type: none"> <li><b>A.</b> Accu-Chek Test Strips</li> <li><b>B.</b> Accutrend Test Strips</li> <li><b>C.</b> FreeStyle Test Strips</li> <li><b>D.</b> TRUE METRIX Test Strips</li> <li><b>E.</b> Precision XTRA Test Strips</li> </ul> </li> <li>2. Patients using an insulin pump/meter system that is not compatible with one of the available formulary alternatives</li> </ol> <p><b><u>Standard/Performance/Value/Advantage/Total Savings</u></b><br/> <b>Glucose Test Strips (non-formulary)</b> are considered medically necessary when <b>ONE</b> of the following is met (1 <u>or</u> 2):</p> <ol style="list-style-type: none"> <li>1. Patient has tried <b>ONE</b> of the following (A, B, <u>or</u> C): <ul style="list-style-type: none"> <li><b>A.</b> FreeStyle Test Strips</li> <li><b>B.</b> TRUE METRIX Test Strips</li> <li><b>C.</b> Precision XTRA Test Strips</li> </ul> </li> <li>2. Patients using an insulin pump/meter system that is not compatible with one of the available formulary alternatives</li> </ol> |
| <b>Pen Needles</b><br>(non-formulary)         | <p><b><u>Standard/Performance/Legacy/Value/Advantage/Total Savings:</u></b><br/> <b>Pen needles (non-formulary)</b> are considered medically necessary when <b>ONE</b> of the following is met (1 <u>or</u> 2):</p> <ol style="list-style-type: none"> <li>1. Patient has tried BD/Embecta Pen Needles</li> <li>2. Patient requires a needle of the requested length and/or gauge which is not available as a BD/Embecta pen needle product</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |
| <b>Syringes</b><br>(non-formulary)            | <p><b><u>Standard/Performance/Legacy/Value/Advantage/Total Savings:</u></b><br/> <b>Syringes (non-formulary)</b> are considered medically necessary when <b>ONE</b> of the following is met (1 <u>or</u> 2):</p>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

| Product | Criteria                                                                                                                                                                                                                              |
|---------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|         | <ol style="list-style-type: none"> <li>1. Patient has tried BD/Embecta Syringes</li> <li>2. Patient requires a syringe of the requested length, volume and/or gauge which is not available as a BD/Embecta syringe product</li> </ol> |

#### Individual and Family Plans:

| Product                                       | Criteria                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  |
|-----------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Glucose Meters</b><br>(non-formulary)      | <p><b>Glucose Meters (non-formulary)</b> are considered medically necessary when <b>ONE</b> of the following is met (1, 2, or 3):</p> <ol style="list-style-type: none"> <li>1. Patient has tried <b>ONE</b> of the following (A, B, <u>or</u> C): <ol style="list-style-type: none"> <li>A. FreeStyle Glucose Meter</li> <li>B. TRUE METRIX Glucose Meter</li> <li>C. Precision XTRA Glucose Meter</li> </ol> </li> <li>2. Patient is using an insulin pump/meter system that is not compatible with one of the available formulary alternatives</li> <li>3. Patients who are blind or significantly visually impaired who are requesting a meter with audio capabilities</li> </ol> <p><b>NOTE:</b> Meters with audio capabilities include Advocate (Redi-Code plus speaking meter), Arkray (Glucocard Expression, Glucocard Shine Express), Foracare (Fora D40D, Fora D40G, For a Gtel, Fora Premium V10 BLE, Fora Test N' Go Advance Voice, Fora Tn'G Voice, Fora V30), Oak Tree Health (EasyMax V, Fortiscare V3), Omnis Health (Embrace Talk), Prodigy (Prodigy Autocode, Prodigy Voice), Relion Premier Voice.</p> |
| <b>Glucose Test Strips</b><br>(non-formulary) | <p><b>Glucose Test Strips (non-formulary)</b> are considered medically necessary when <b>ONE</b> of the following is met (1 <u>or</u> 2):</p> <ol style="list-style-type: none"> <li>1. Patient has tried <b>ONE</b> of the following (A, B, <u>or</u> C): <ol style="list-style-type: none"> <li>A. FreeStyle Test Strips</li> <li>B. TRUE METRIX Test Strips</li> <li>C. Precision XTRA Test Strips</li> </ol> </li> <li>2. Patients using an insulin pump/ meter system that is not compatible with one of the available formulary alternatives</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| <b>Lancets</b> (non-formulary)                | <p><b>Lancets (non-formulary)</b> are considered medically necessary when <b>ONE</b> of the following is met (1 <u>or</u> 2):</p> <ol style="list-style-type: none"> <li>1. Patient has tried <b>ONE</b> of the following (A <u>or</u> B): <ol style="list-style-type: none"> <li>A. FreeStyle Lancets</li> <li>B. TRUEplus Lancets</li> </ol> </li> <li>2. Patient was unable to adhere to a regimen using standard insulin products</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
| <b>Lancing Devices</b><br>(non-formulary)     | <p><b>Lancing Devices (non-formulary)</b> are considered medically necessary when <b>ONE</b> of the following is met (1 <u>or</u> 2):</p> <ol style="list-style-type: none"> <li>1. Patient has tried TRUEdraw lancing device</li> <li>2. Patient was unable to adhere to a regimen using the preferred product(s)</li> </ol>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |

When coverage is available and medically necessary, the dosage, frequency, duration of therapy, and site of care should be reasonable, clinically appropriate, and supported by evidence-based literature and adjusted based upon severity, alternative available treatments, and previous response to therapy.

Receipt of sample product does not satisfy any criteria requirements for coverage.

## References

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10. US Department of Health and Human Services. Food and Drug Administration. Center for Devices and radiological health Office of In Vitro Diagnostic Device Evaluation and Radiological health. Division of Chemistry and Toxicology Devices. Self-monitoring blood glucose test systems for over-the-counter use. Guidance for industry and Food and Drug Administration Staff. September 2020. Available at: <http://www.fda.gov/downloads/MedicalDevices/DeviceRegulationandGuidance/GuidanceDocuments/UCM380327.pdf>. Accessed on September 13, 2023.

## Revision Details

| Type of Revision | Summary of Changes                                                                                                                                                                                                                                                                                                                                                                | Date       |
|------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
| Annual Review    | <b>Updated</b> preferred product criteria including (1) reducing step through from two preferred products to one preferred product, (2) added using non-compatible insulin pump/meter system option, (3) added criteria option if patient is using Freestyle Libre reader<br><b>Updated</b> Standard and Performance to include Accu-chek and Accutrend as preferred alternatives | 09/01/2024 |

|                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                 |            |
|-------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------|
|                   | <b>Added</b> Diabetic Pen Needles criteria from Pen Needles IP0569<br><b>Updated</b> title from Glucose Test Strips<br><b>Added</b> glucose test strips, lancets and criteria for the related IFP non-formulary classes.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                        |            |
| Selected Revision | <b>Updated</b> the policy title.<br><b>Updated</b> the Employer Plans pen needle preferred product from "BD Pen Beedles" to "BD/Embecta Pen Needles."<br><b>Added</b> Syringes to the policy, for Employer Plans.<br><b>Added</b> Lancing Devices to the policy, for Individual and Family Plans.                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | 07/01/2025 |
| Selected Revision | <b>Employer Plans:</b><br><b>Added</b> FreeStyle and TRUE METRIX test strips to preferred alternatives and <b>removed</b> OneTouch test strips.<br><b>Removed</b> criterion for FreeStyle Precision strips used with Freestyle Libre reader.<br><b>Individual and Family Plans:</b><br><b>Added</b> Glucose Meters to the policy.<br><b>Added</b> FreeStyle and TRUE METRIX test strips to preferred alternatives and <b>removed</b> OneTouch test strips<br><b>Removed</b> criterion for FreeStyle Precision strips used with Freestyle Libre reader<br><b>Added</b> FreeStyle and TRUEplus lancets to preferred alternatives and <b>removed</b> OneTouch lancets<br><b>Added</b> TRUEdraw lancing device to preferred alternative and <b>removed</b> OneTouch lancing device. | 10/1/2025  |
| Selected Revision | <b>Added</b> Simpli pen needles to coverage policy keywords.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | 10/15/2025 |
| Selected Revision | <b>Added</b> Precision XTRA test strips and meters to coverage policy.                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          | 11/1/2025  |

The policy effective date is in force until updated or retired.

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