

FREESTYLE LIBRE CONTINUOUS GLUCOSE MONITORING PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY

PATIENT INFORMATION			
Name:	DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Phone:
Street/City/State/Zip:			

PRESCRIPTION	
Order Type <small>Choose 1</small>	<input type="checkbox"/> New CGM (patient never had before) <input type="checkbox"/> Replacement CGM (What brand/model did patient use before): _____
System <small>Choose 1</small>	<input type="checkbox"/> Freestyle Libre 14 Day System Dispense Qty: <input type="checkbox"/> 1 Refills: <input type="checkbox"/> 0 <input type="checkbox"/> Other: _____ Sig: Use as directed to test glucose levels. Additional Notes: _____ <input type="checkbox"/> Freestyle Libre 2 System Dispense Qty: <input type="checkbox"/> 1 Refills: <input type="checkbox"/> 0 <input type="checkbox"/> Other: _____ Sig: Use as directed to test glucose levels. Additional Notes: _____ <input type="checkbox"/> Freestyle Libre 3 System Dispense Qty: <input type="checkbox"/> 1 Refills: <input type="checkbox"/> 0 <input type="checkbox"/> Other: _____ Sig: Use as directed to test glucose levels. Additional Notes: _____
CGM Products <small>Check all that apply</small>	<input type="checkbox"/> Reader (E2103) <i>DME ONLY: 1/365</i> Dispense Qty: <input type="checkbox"/> 1 Refills: <input type="checkbox"/> 0 <input type="checkbox"/> Other: _____ Sig: Use to check glucose daily. Additional Notes: _____ <input type="checkbox"/> Sensors (A4239) <i>DME ONLY: 6/84</i> Dispense Qty: <input type="checkbox"/> 2 (1 mth) <input type="checkbox"/> 6 (3 mths) <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 11 <input type="checkbox"/> 4 <input type="checkbox"/> Other: _____ Sig: Site change per manufacturer recommendation, every 14 days. Additional Notes: _____

STATEMENT OF MEDICAL NECESSITY (PHYSICIAN USE ONLY)			
Diagnosis (ICD-10): Type 1: <input type="checkbox"/> E10.9 <input type="checkbox"/> E10.65 Type 2: <input type="checkbox"/> E11.9 <input type="checkbox"/> E11.65 <input type="checkbox"/> Other: _____			
Duration of Need: <input type="checkbox"/> Lifetime <input type="checkbox"/> Other: _____		<small>*Lifetime equals 12 months for non-Medicare. If no duration is specified, prescription defaults to lifetime</small>	
Current Insulin Regimen: <input type="checkbox"/> Insulin Pump <input type="checkbox"/> Multiple Daily Injections (How many injections per day: _____)			
Prescribed # of glucose tests per day:	Blood glucose value range:	to	mg/dL # SMBG/day: to per day
Fasting Hyperglycemia: mg/dL	Date:	Latest HbA1c Result:	Date:

SUPPORTING CLINICAL INDICATIONS
<input type="checkbox"/> History of hypoglycemia unawareness
<input type="checkbox"/> History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity and/or very low insulin requirements)
<input type="checkbox"/> History of nocturnal hypoglycemia
<input type="checkbox"/> Recurring episodes of severe hypoglycemia
<input type="checkbox"/> Evidence of unexplained severe hypoglycemia
<input type="checkbox"/> Patient has been hospitalized or has required paramedical treatment for low blood sugar
<input type="checkbox"/> Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL
<input type="checkbox"/> Day-to-day variations in work schedule, mealtimes and/or activity level, which confound the degree of regimentation required to self-manage glycemia with multiple insulin injections
<input type="checkbox"/> History of suboptimal glycemic control before or during pregnancy
<input type="checkbox"/> Poor glycemic control as evidenced by 72 hour CGMS sensing trial
<input type="checkbox"/> Multiple alterations in self-monitoring and insulin administration regimens to optimize care
<input type="checkbox"/> Patient and/or caregiver has completed comprehensive diabetes education
<input type="checkbox"/> Patient has demonstrated ability to self-monitor blood glucose levels as recommended by Physician
<input type="checkbox"/> Patient is motivated to achieve and maintain improved glycemic control

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a Continuous Glucose Monitoring Device and supplies. I certify that I am the physician identified in the below section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

PHYSICIAN INFORMATION		
Physician:	NPI #:	
Hospital/Clinic:	Phone #:	Fax #:
Street/City/State/Zip:		

Signature: _____ Date: _____