DEXCOM CONTINUOUS GLUCOSE MONITORING

PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY

PATIENT INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Email: _____ Phone: _____

PRESCRIPTION

Order Type *Choose 1*	☐ New CGM (Patient never had before) ☐ Replacement CGM (What brand/model did the patient use before?): _____
CGM Products *Check all that apply*	☐ Dexcom G7 Receiver (A9278/E2103) *DME ONLY: 1/365* **Dispense Qty:** ☐ 1 **Refills:** ☐ 0 ☐ Other: _____ **Sig:** Use to check glucose daily. Additional Notes: _____ ☐ Dexcom G7 15 Day Sensors (A9276/A4239) *DME ONLY: 6/90* **Dispense Qty:** ☐6 (90 days) ☐Other:_____ **Refills:** ☐4 ☐Other:_____ **Sig:** Site change per manufacturer recommendation, every 15 days. Additional Notes: _____ ☐ Dexcom G7 Sensors (A9276/A4239) *DME ONLY: 9/90* **Dispense Qty:** ☐9 (90 days) ☐Other:_____ **Refills:** ☐4 ☐Other:_____ **Sig:** Site change per manufacturer recommendation, every 10 days. Additional Notes: _____
Supplies *Check all that apply*	☐ IV Prep Wipes (100/order) Dispense Qty: _____ Refills: _____ Sig: Use to prep skin before applying sensor. Additional notes: _____ ☐ Transparent Dressings (100/order) Dispense Qty: _____ Refills: _____ Sig:

SUPPORTING CLINICAL INDICATIONS

☐ Recurrent episodes of severe hypoglycemia with BG's less than 50 mg/dL. Frequency of episodes: _____
☐ Hemoglobin HbA1C level is 7.0% or 1% over upper range of normal
☐ History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity and/or very low insulin requirements)
☐ Wide fluctuations in prepandial BG levels (e.g., levels commonly exceed 100 mg/dL)
☐ Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL
☐ 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
☐ History of suboptimal glycemic control before or during pregnancy
☐ Suboptimal glycemic and metabolic control after renal transplantation
☐ Poor glycemic control evidenced by 72-hour CGMS sensing trial

Has the patient been on a program of multiple daily injections or insulin with frequent self-adjustment of insulin dose for at least 6 months prior to the initiation of the insulin pump?
☐ Yes ☐ No

SUPPORTING CRITERIA (PHYSICIAN TO CHECK ALL THAT APPLY)

☐ Patient has completed comprehensive diabetes education
☐ Patient has demonstrated ability to self-monitor blood glucose levels as recommended by Physician
☐ Patient has been hospitalized or required paramedical treatment for low blood sugar
☐ Patient is motivated to achieve and maintain improved glycemic control

Insulin Reaction Notes: _____ | Additional Notes: _____

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 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 in fact in that section may be subject me to civil or criminal liability.

PHYSICIAN INFORMATION

Physician name: _____ NPI: _____

Hospital/Clinic: _____ Phone: _____

Address: _____ Fax: _____

Signature: _____ Date: _____