FREESTYLE LIBRE 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?): _____	
System *Choose 1*	☐ Freestyle Libre 14 Day System ☐ Freestyle Libre 2+ System ☐ Freestyle Libre 3+ System	Dispense Qty: 1 Refills: ☐ 0 ☐ Other _____ Sig: Use as directed to test glucose levels. Additional Notes: _____
CGM Products *Check all that apply*	☐ Reader (E2103) *DME ONLY: 1/365* Dispense Qty: ☐ 1 Refills: ☐ 0 ☐ Other: _____ Sig: Use to check glucose daily. Additional Notes: _____ ☐ Sensors (A4239) *DME ONLY: 6/84* Dispense Qty: ☐ 2 (1 mth) ☐ 6 (3 mths) ☐ Other: _____ Refills: ☐ 11 ☐ 4 ☐ Other _____ Sig: Site change per manufacturer recommendation, every 14 days. Additional Notes: _____	

STATEMENT OF MEDICAL NECESSITY (PHYSICIAN USE ONLY)

Diagnosis (ICD-10): Type 1: ☐ E10.9 ☐ E10.65 **Type 2:** ☐ E11.9 ☐ E11.65 ☐ **Other:** _____		
Duration of Need: ☐ Lifetime ☐ Other: _____ *Lifetime equals 12 months for non-Medicare. If no duration is specified, prescription defaults to lifetime.		
Current Insulin Regimen: ☐ Insulin Pump ☐ 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

☐ History of hypoglycemia unawareness
☐ History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity and/or very low insulin requirements)
☐ History of nocturnal hypoglycemia
☐ Recurring episodes of severe hypoglycemia
☐ Evidence of unexplained severe hypoglycemia
☐ Patient has been hospitalized or has required paramedical treatment for low blood sugar
☐ 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 glycemia control before or during pregnancy
☐ Poor glycemia control as evidenced by 72-hour CGMS trial
☐ Multiple alterations in self-monitoring and insulin administration regimens to optimize care
☐ Patient and/or caregiver has completed comprehensive diabetes education
☐ Patient has demonstrated ability to self-monitor blood glucose levels as recommended by Physician
☐ 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 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: _____