bedard
Pharmacy & Medical Supplies

Phone: 207-784-3700 | Fax: 207-795-7622

FREESTYLE LIBRE CONTINUOUS GLUCOSE MONITORING PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY

PATIENT INFORMATION			
Name:	DOB:	Gender: ☐ Male ☐ Female	Phone:
Street/City/State/Zip:			

PRESCRIPTION

Order Type *Choose 1*

☐ New CGM (patient never had before)

☐ Replacement CGM *(What brand/model did patient use before)*:_____

System *Choose 1*

☐ Freestyle Libre 14 Day System ☐ Freestyle Libre 2 System

☐ Freestyle Libre 3 System

☐ Freestyle Libre 3 Plus System ☐ Freestyle Libre 2 Plus 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 glycemic control before or during pregnancy
- ☐ Poor glycemic control as evidenced by 72 hour CGMS sensing 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 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:_____

PLEASE FAX COMPLETED FORM TO BEDARD PHARMACY & MEDICAL SUPPLIES: 207-795-7622