Resupply Order Form
Continuous Glucose Monitoring

Complete and Return
Fax to (207) 795-7622

PATIENT INFORMATION
(PLEASE INCLUDE LAST 2 OFFICE VISIT NOTES)

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Patient Email: _____ Phone: _____

ORDER INFORMATION

Date of Last Office Visit: _____

Length of Need: _____ Number of Refills: _____

ICD-10 Dx Code: ☐E10.9 ☐ E10.65 ☐ E11.9 ☐ E11.65 ☐ Other: _____

PRESCRIBED ITEMS

CGM Brand:

- ☐ **Medtronic Simplera** (site change per manufacturer's recommendation, 1 every 6 days) Dispense Qty _____
- ☐ **Medtronic Instinct** (site change per manufacturer's recommendation, 1 every 15 days) Dispense Qty _____
- ☐ **Medtronic Guardian** (site change per manufacturer's recommendation, 1 every 7 days) Dispense Qty _____
- ☐ **Dexcom G7** (site change per manufacturer's recommendation, 1 every 10 days) Dispense Qty _____
- ☐ **Dexcom G7 15-Day Wear** (site change per manufacturer's recommendation, 1 every 15 days) Dispense Qty _____
- ☐ **Libre 2 Plus** (site change per manufacturer's recommendation, 1 every 15 days) Dispense Qty _____
- ☐ **Libre 3 Plus** (site change per manufacturer's recommendation, 1 every 15 days) Dispense Qty _____

CGM Components:

- ☐ **CGM Receiver/Monitor**
  - E2103 (Change 1 every 5 years)
  - E2102 (Change 1 every 5 years)
  - A9278 (Change 1 every 365 days)
- ☐ **CGM Sensors**
  - A4239 (Bill 1 every month or 3 every 3 months)
  - A4238 (Bill 1 every month or 3 every 3 months)
  - A9276 (1 unit per day)
- ☐ **CGM Transmitter**
  - A4239 (Bill 1 every 3 months)
  - A9277 (Fasten on top of sensors to check glucose daily. 1 every 365 days for Medtronic)

Accessories:

☐ IV Prep Wipes ☐ Adhesive Remover ☐ Skin Prep ☐ Transparent Dressings ☐ Other: _____

QUALIFICATIONS

Medicare patients must meet the following guidelines to qualify:

- •Patient has Diabetes
- •Patient is insulin treated or has a history of problematic hypoglycemia with documentation
- •Patient is required to have and use receiver with CGM system
- •Patient is seen within six (6) months prior to ordering the CGM, to evaluate their Diabetes control

PHYSICIAN INFORMATION

Physician name: _____ NPI: _____

Hospital/Clinic: _____ Phone: _____

Address: _____ Fax: _____