bedard
Pharmacy & Medical Supplies

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

DEXCOM CONTINUOUS GLUCOSE MONITORING PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY

PATIENT INFORMATION

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

PRESCRIPTION

Order Type *Choose one*

☐ New CGM (patient never had before) ☐ Replacement CGM

If yes, what brand/model did patient use before:_____

CGM Products *Check all that apply*

☐ Dexcom **G6** Receiver (A9278/E2103) *DME ONLY: 1/365*
Dispense Qty: ☐ 1 Refills: ☐ 0 ☐ Other:_____
Sig: Use to check glucose daily. Additional Notes:

☐ Dexcom **G6** 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:

☐ Dexcom **G6** Transmitter (A9277/A4239) *DME ONLY: 1/90*
Dispense Qty: ☐ 1 (90 days) ☐ Other:_____ Refills: ☐ 4 ☐ Other:_____
Sig: Site change per manufacturer recommendation, every 90 days.
Additional Notes:

☐ 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** 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:

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

# Multiple Daily Injections per day:	Blood glucose value range: to mg/dL
Latest HbA1c Result: Date:	# SMBG/day: to per day

SUPPORTING CLINICAL INDICATIONS (PHYSICIAN TO CHECK ALL THAT APPLY)

☐ 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 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