

FREESTYLE LIBRE CONTINUOUS GLUCOSE MONITORING PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY

PATIENT INFORMATION			
Name:		DOB:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Phone:			
Street/City/State/Zip:			
PRESCRIPTION			
Order Type <small>Choose one</small>	<input type="checkbox"/> New CGM (patient never had before) <input type="checkbox"/> Replacement CGM What brand/model did patient use before: _____		
System <small>Choose one</small>	<input type="checkbox"/> Freestyle Libre 14 Day System Dispense Qty: <input type="checkbox"/> 1 Refills: <input type="checkbox"/> 0 <input type="checkbox"/> Other: _____ Sig: Use as directed to test glucose levels. Additional Notes:		
	<input type="checkbox"/> Freestyle Libre 2 System Dispense Qty: <input type="checkbox"/> 1 Refills: <input type="checkbox"/> 0 <input type="checkbox"/> Other: _____ Sig: Use as directed to test glucose levels. Additional Notes:		
CGM Products <small>Check all that apply</small>	<input type="checkbox"/> Reader (K0554) <i>DME ONLY: 1/365</i> Dispense Qty: <input type="checkbox"/> 1 Refills: <input type="checkbox"/> 0 <input type="checkbox"/> Other: _____ Sig: Use to check glucose daily. Additional Notes:		
	<input type="checkbox"/> Sensors (K0553) <i>DME ONLY: 6/84</i> Dispense Qty: <input type="checkbox"/> 2 (1 mth) <input type="checkbox"/> 6 (3 mths) <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 11 <input type="checkbox"/> 4 <input type="checkbox"/> Other: _____ Sig: Site change per manufacturer recommendation, every 14 days. Additional Notes:		
STATEMENT OF MEDICAL NECESSITY (PHYSICIAN USE ONLY)			
Diagnosis (ICD-10): Type 1: <input type="checkbox"/> E10.9 <input type="checkbox"/> E10.65 Type 2: <input type="checkbox"/> E11.9 <input type="checkbox"/> E11.65 <input type="checkbox"/> Other:			
Duration of Need: <input type="checkbox"/> Lifetime <input type="checkbox"/> Other: _____ *Lifetime equals 12 months for non-Medicare. If no duration is specified, prescription defaults to lifetime			
Current Insulin Regimen: <input type="checkbox"/> Insulin Pump <input type="checkbox"/> 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			
<input type="checkbox"/> History of hypoglycemia unawareness			
<input type="checkbox"/> History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity and/or very low insulin requirements)			
<input type="checkbox"/> History of nocturnal hypoglycemia			
<input type="checkbox"/> Recurring episodes of severe hypoglycemia			
<input type="checkbox"/> Evidence of unexplained severe hypoglycemia			
<input type="checkbox"/> Patient has been hospitalized or has required paramedical treatment for low blood sugar			
<input type="checkbox"/> Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL			
<input type="checkbox"/> 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			
<input type="checkbox"/> History of suboptimal glycemic control before or during pregnancy			
<input type="checkbox"/> Poor glycemic control as evidenced by 72 hour CGMS sensing trial			
<input type="checkbox"/> Multiple alterations in self-monitoring and insulin administration regimens to optimize care			
<input type="checkbox"/> Patient and/or caregiver has completed comprehensive diabetes education			
<input type="checkbox"/> Patient has demonstrated ability to self-monitor blood glucose levels as recommended by Physician			
<input type="checkbox"/> 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: _____