

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 <i>Choose one</i>	<input type="checkbox"/> New CGM (patient never had before) <input type="checkbox"/> Replacement CGM What brand/model did patient use before: _____
System <i>Choose one</i>	<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. <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.
CGM Products <i>Check all that apply</i>	<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: 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

<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 #:
Street/City/State/Zip:	Fax #:

Signature: _____ Date: _____

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