



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: <input type="checkbox"/> Male <input type="checkbox"/> Female
Phone:		
Street/City/State/Zip:		

PRESCRIPTION

Order Type Choose one	<input type="checkbox"/> New CGM (patient never had before) <input type="checkbox"/> Replacement CGM What brand/model did patient use before: _____
CGM Products Check all that apply	<input type="checkbox"/> Dexcom G6 Receiver (A9278/K0554) DME ONLY: 1/365 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"/> Dexcom G6 Sensors (A9276/K0553) DME ONLY: 9/90 Dispense Qty: <input type="checkbox"/> 9 (90 days) <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 4 <input type="checkbox"/> Other: _____ Sig: Site change per manufacturer recommendation, every 10 days. Additional Notes: _____
	<input type="checkbox"/> Dexcom G6 Transmitter (A9277/K0553) DME ONLY: 1/90 Dispense Qty: <input type="checkbox"/> 1 (90 days) <input type="checkbox"/> Other: _____ Refills: <input type="checkbox"/> 4 <input type="checkbox"/> Other: _____ Sig: Fasten on top of sensors to check glucose daily. Additional Notes: _____
Supplies Check all that apply	<input type="checkbox"/> IV Prep Wipes (100/order) Dispense Qty: _____ Refills: _____ Sig: Use to prep skin before applying sensor. Additional Notes: _____
	<input type="checkbox"/> 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)

<input type="checkbox"/> Recurrent episodes of severe hypoglycemia with BG's less than 50 mg/dL. Frequency of episodes:
<input type="checkbox"/> Hemoglobin HbA1C level is 7.0% or 1% over upper range of normal
<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"/> Wide fluctuations in preprandial BG levels (e.g., levels commonly exceed 100 mg/dL)
<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"/> Suboptimal glycemic and metabolic control after renal transplantation
<input type="checkbox"/> 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)**

<input type="checkbox"/> Patient 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 has been hospitalized or required paramedical treatment for low blood sugar	<input type="checkbox"/> Patient is motivated to achieve and maintain improved glycemic control

Insulin reaction notes:	Additional notes:
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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