



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 <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: _____		
CGM Products <i>Check all that apply</i>	<input type="checkbox"/> Dexcom G6 Receiver (A9278/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"/> Dexcom G6 Sensors (A9276/K0553) <i>DME ONLY: 9/90</i> 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) <i>DME ONLY: 1/90</i> 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 <i>Check all that apply</i>	<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: <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			
# 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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:	
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