Written Order and CMN for Continuous Glucose Monitoring (CGM)

PATIENT INFORMATION:		
Name:		
Address:		
City, ST, Zip:		
Phone:	**Date of Birth:**	**Account #:**

DOCTOR INFORMATION:	
Name:	
Address:	
City, ST, Zip:	
Phone:	**Fax:**
NPI:	**License #:**

PRODUCT INFORMATION *(please check the items that you are prescribing):*

I am prescribing the following – please check the appropriate manufacturer.
[code definitions: A9278/K0554/E2102 receiver/reader; A9277 transmitter; A9276/K0553/A4238 sensors]

- ☐ Abbott FreeStyle Libre A9278/K0554/E2103 (qty 1), A9276/K0553/A4239 (qty 30/mo), A5120/A6257 (qty 10/mo)
- ☐ Dexcom A9278/K0554/E2103 (qty 1), A9277 (qty 4), A9276/K0553/A4239 (qty 30/mo), A5120/A6257 (qty 10/mo)
- ☐ Medtronic A9278/E2102 (qty 1), A9277 (qty 2), A9276/A4238 (qty 30/month), A5120/A6257 (qty 10/mo)
- ☐ Senseonics Eversense A9277 (qty 2), A9276 (qty 30/month), A5120/A6257 (qty 10/mo)

If there are any specific instructions, list here:_____

MEDICAL INFORMATION *(please check and/or complete the appropriate responses):*

1. YES ☐ NO ☐ Has the patient been compliant with their physician-ordered diabetes treatment plan?
2. YES ☐ NO ☐ Has the patient been using a home glucose monitor and testing at least 4x per day?
3. YES ☐ NO ☐ Is the patient being treated with at least 3 multiple daily insulin injections or using an insulin pump?
4. YES ☐ NO ☐ Does the patient need to make frequent adjustments to their insulin?
5. ☐ Patient experiences hypoglycemia: Frequent ☐ Overnight ☐ Diagnosis Code: _____
6. ☐ Patient has hypoglycemia unawareness
7. ☐ Patient experiences (check):
   Nerve Problems ☐ Eye Problems ☐ Loss of Feeling in Feet ☐ Kidney Problems ☐
8. ☐ Patient has had Glucagon administrations
9. ☐ Patient has elevated HbA1C (enter the value) _____
10. ☐ Patient has been to the emergency room due to complications
11. ☐ Patient will be supervised by physician and/or diabetes educator
12. ☐ Patient has been hospitalized for (check): Hypoglycemia ☐ DKA ☐
13. What is the patient's ICD10 diagnosis? _____
14. What is the date of the patient's last office visit? _____

I certify the medical necessity of these items for this patient. The medical information on this form and any statement on my letterhead attached hereto has been completed by me or my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that my falsification, omission, or concealment of material fact may subject me to civil or criminal liability. I certify that I am a physician who manages multiple patients on continuous subcutaneous insulin therapy and work closely with a team of nurses, diabetes educators, and dietitians knowledgeable in insulin pump therapy and evaluating the patient every 3 months.

Physician Signature: no stamps please	Date:

Prescription valid for one year from signature date.

or return to: **FAX: (502) 657-0237**

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