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/E2103 receiver/reader; A9277 transmitter; A9276/K0553/A4238/A4239 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. How many times per day has the patient been testing their blood sugar with a home glucose monitor? _____
3. How many daily insulin injections is the patient taking? _____ If inhaled, check here ☐
4. YES ☐ NO ☐ Is the patient using an insulin pump?
5. YES ☐ NO ☐ Can the patient adjust their insulin based on glucose reading results or with carb counting?
6. ☐ Patient experiences hypoglycemia: Frequent ☐ Overnight ☐ Diagnosis Code: _____
7. ☐ Patient has hypoglycemia unawareness
8. ☐ Patient experiences (check):
   Nerve Problems ☐ Eye Problems ☐ Loss of Feeling in Feet ☐ Kidney Problems ☐
9. ☐ Patient has had Glucagon administrations
10. ☐ Patient has elevated HbA1C (enter the value) _____
11. ☐ Patient has been to the emergency room due to complications
12. ☐ Patient will be supervised by physician and/or diabetes educator
13. ☐ Patient has been hospitalized for (check): Hypoglycemia ☐ DKA ☐
14. What is the patient's ICD10 diagnosis? _____
15. 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**

Edwards Health Care Services, Inc. (EHCS) 5640 Hudson Industrial Parkway, Hudson, OH 44236
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