Address: 8031 Ortonville Road,
Ste. 150, Clarkston, MI 48348
Office: (810) 208-6006

CGM Physician Written Order Form

Please fax completed form to: (810) 208-6007

(1) Patient Contact Information

Name: ______________________ **Date of Birth:** ______________________ **Phone Number:** ______________________

Address, City, State, Zip Code: ____

Insurance Provider: ______________________ **Insurance ID:** ______________________ **Insurance Phone #:** ______________________

(2) Order Information

Start Date: __________ **Length of Need:** ______________________ ☐ FreeStyle Libre ☐ Dexcom Product: ______________________

Diagnosis (ICD – 10): ☐ E10.9 ☐ E10.65 ☐ E11.9 ☐ E11.65 ☐ Z79.4 ☐ Other ______________________

Prescribed Items: ☐ Receiver ☐ Transmitter ☐ Sensors ☐ Other ______________________

(3) Qualification (As Documented in Patient Medical Records)

Is the patient new to CGM therapy? ☐ Yes ☐ No **HbA1C:** **Date:** **Fluctuation of BG Values:**

To be eligible for coverage of a CGM and related supplies, the beneficiary must meet all the following coverage criteria (1 – 5):

1. The beneficiary has diabetes mellitus (refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses)
2. The beneficiary's treating practitioner has concluded that the beneficiary has sufficient training using CGM prescribed as evidence by providing a prescription
3. The CGM is prescribed in accordance with its FDA indications for use
4. The beneficiary for whom a CGM is being prescribed, to improve glycemic control, meets at least one of the criteria below:
   - **A)** The beneficiary is insulin-treated; or
   - **B)** The beneficiary has a history of problematic hypoglycemia with documentation of at least one of the following: Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL(3.0mmol/L)) that persists despite multiple attempts to adjust medication(s) and/ or modify the diabetes treatment plan; or, a history of one level 3 hypoglycemic event (glucose<54mg/dL (3.0mmol/L)) characterized by altered mental and/ or physical state requiring third-party assistance for treatment of hypoglycemia
5. Within (6) months prior to ordering the CGM, the treating practitioner has an in-person or Medicare approved telehealth visit with the beneficiary to evaluate their diabetes control and determined (1)-(4) above are met

(4) Confirmation

Prescriber's Signature: ______________________ **Printed Name:** ______________________

Facility Address: ______________________ **Date:** ______________________

NPI #: ______________________ **Revised:** ______________________

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for the continuous glucose monitoring and associated diabetes supplies listed. I certify, to the best of my knowledge, that the medical necessity information contained in this document is true, accurate, and complete.

~Please Attach & Include Medical Records & Insurance Information~