CGM Physician's Order

Changes to form must be initialed and dated by prescriber

Complete and Fax Toll Free To: 800.824.2320

FORM IS NOT VALID UNLESS ALL SECTIONS ARE COMPLETE.

CCS Medical Rep: _____

Phone Number: _____

PATIENT INFORMATION (PLEASE ATTACH PATIENT DEMOGRAPHIC SHEET)

1. Name: _____ DOB: _____ Phone #: _____
   Address: _____ City: _____ State: _____ Zip: _____
   Insurance Provider: _____ ID #: _____ Insurance Phone #: _____

ORDER INFORMATION

2. ☐ Order Start Date

3. Length of Need: 12 months unless noted _____

4. Diagnosis (ICD-10):
   ☐ E10.9 ☐ E10.65 ☐ 024.419 Gestational Diabetes Other: _____

5. Prescribed Items (Cross out supplies not being prescribed):
   Transmitter Receiver Sensors Insertion Device Dressings Tape Wipes Adhesive Remover

6. Brand:
   ☐ Dexcom ☐ Medtronic Enlite Other:_____

7. Site Change and Frequency:
   ☐ Sensor site changes per manufacturer recommendation, up to 90-day supply
   Sensor site changes (other)_____, up to 90-day supply
   Transmitter: 1 every 6 months Transmitter Kit*: 1 every 6 months Receiver: 1 every 12 months
   *Transmitter kit contains two transmitters and equals 1 billing unit.

   NOTE: For site changes more than manufacturer recommendation, please submit supporting medical records.

QUALIFICATIONS (AS DOCUMENTED IN PATIENT MEDICAL RECORDS)

8. ☐ Patient is New to CGM Therapy
   ☐ Patient is Currently on CGM Therapy

   Fill out below if patient is NEW or CURRENTLY on CGM Therapy (Required for Pre-Auth)

9. HbA1C: ☐ Date: ☐ Fluctuations of BG Values: ☐ to ☐

10. The patient complies with regimen of 4 or more finger sticks per day and 3 or more insulin injections per day unless on an insulin pump and demonstrates the following:
    - ☐ Recurrent, unexplained, severe, symptomatic (generally blood glucose levels less than 50 mg/dL) hypoglycemia and this hypoglycemia puts the patient or others at risk
    - ☐ Recurrent episodes of diabetic ketoacidosis, hypoglycemia or both, resulting in recurrent and/or prolonged hospitalization
    - ☐ Discordant HbA1C and finger stick blood glucose levels (i.e., patient with consistent normal blood glucose levels at home but high HbA1C levels)
    - ☐ Frequent nocturnal hypoglycemia, less than 50mg/dL
    - ☐ Inadequate glycemic control, demonstrated by HbA1C measurements between 7% and 10% despite compliance with frequent self-monitoring and multiple alterations in self-monitoring and insulin administration regimens to optimize care
    - ☐ Wide fluctuations in blood sugar patterns over time (<50 mg/dL, or >150 mg/dL)
    - ☐ Poor glycemic control as evidenced by 72 hour CGMS sensing trial
    - ☐ Patient has been hospitalized or has required paramedical treatment for low blood sugar
    - ☐ History of suboptimal glycemic control before or during pregnancy

PRESCRIBER INFORMATION AND SIGNATURE

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. The patient/caregiver is able to use these items as prescribed; is scheduled or has had training for these items; and is informed about and consented to CCS Medical contact and insurance eligibility verification.

11. ▶ Date: _____ (Date Stamps NOT Accepted) ▶ Prescriber Signature: _____ (Signature Stamps NOT Accepted. Prescriber's name and NPI # MUST be printed on this form)

12. Facility Name _____
    Address _____
    _____
    Phone _____
    Fax _____

    ☐ Name _____ NPI#: _____
    ☐ Name _____ NPI#: _____
    ☐ Name _____ NPI#: _____
    ☐ Name _____ NPI#: _____