## Standard Written Order

| Patient's Name: | | Sex:<br>Male_____ ___ | Date of Birth:<br>_____/_____/_____ |
|---|---|---|---|
| Street Address: | | Apt. # | Home Phone #: |
| City: | State: | | Zip Code: |
| Insurance Policy: | Policy ID: | | Today's Date: |

# Continuous Glucose Monitoring System Prescription Form

**1) The patient has a diagnosis of Diabetes Mellitus (Please include all relevant ICD-10 codes below):**

| | |
|---|---|
| | E10.65 (Type 1 Diabetes Mellitus with hyperglycemia) |
| | E10.9 (Type 1 Diabetes Mellitus without complications) |
| | E11.65 (Type 2 Diabetes Mellitus with hyperglycemia) |
| | E11.8 (Type 2 Diabetes Mellitus with unspecified complications) |
| | E11.9 (Type 2 Diabetes Mellitus without complications) |
| | Other: |

**2) Please provide clinical notes with your order. Medical Records must include the following details:**

| | |
|---|---|
| | Patient has a diagnosis of Diabetes Mellitus that is supported by relevant ICD-10 code(s) |
| | Patient demonstrates compliance with healthcare provider's ordered diabetic treatment plan |
| | Patient tests blood glucose levels at least four times per day using a home-based glucometer and supplies |
| | Patient receives insulin via injections (at least three times/day) or via continuous administration (insulin pump) |
| | Patient required to regularly adjust insulin treatment regimen based upon blood glucose readings |

## *We are pleased to offer the FreeStyle Libre 2 System*

*Please select the needed items below and provide any additional details related to the treatment regimen*

| | | |
|---|---|---|
| | **FreeStyle Libre 2 Reader** (A9278 /E2103) | **Length of Need**: Lifetime (unless noted otherwise) |
| | **FreeStyle Libre 2 Sensors** (A9276 /A4239)<br>○ 1 Unit (30day supply) or 30 units (for A4239)<br>○ 3 Units (90day supply) or 90 units (for A4239) | **Length of Need**: Lifetime (unless noted otherwise)<br>**1 Unit** = **1 month** of sensors<br>**Note:** Sensor changes are based upon manufacturer guidelines |
| | **GEMCORE360° Transparent Thin Film Dressing**, Bag of 10 (included with order) | ○ 2.375" x 2.75"<br>○ 4" x 4.75" |
| | Other: | Please specify details of order for additional item(s): |
| **If patient receives test strips and lancets monthly, please note the date of the last order (if available):**<br>______/______/______ | | |
| **Please include clinical notes from last two office visits with order**<br>**Please indicate the date of the patient's last office visit below:**<br>______/______/______ | | |

☐ The treating provider hereby confirms that the patient's diabetic condition warrants the need for Continuous Glucose Monitoring (CGM) as evidenced by the ICD-10 code(s) selected in section 1, and clinical notes supporting the listed criteria in section 2.

☐ The treating provider hereby confirms that he/she is treating the above patient under a comprehensive plan of care for his/her Diabetes Mellitus. He/she has met with the patient six months prior to ordering CGM, and he/she will continue to meet with the patient every six months from the time the initial order was written.

| Physician Name and Signature: | Today's Date: |
|---|---|
| Phone Number: | NPI: |