Standard Written Order

Patient's Name:	Sex: Male_____ Female_____	Date of Birth: _____/_____/_____
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:

	The beneficiary has diabetes mellitus (Refer to the ICD-10 code list in the LCD-related Policy Article for applicable diagnoses)
	The beneficiary's treating practitioner has concluded that the beneficiary (or beneficiary's caregiver) has sufficient training using the CGM prescribed as evidenced by providing a prescription
	The CGM is prescribed in accordance with its FDA indications for use
	The beneficiary has a history of problematic hypoglycemia with documentation of at least one of the following (see the POLICY SPECIFIC DOCUMENTATION REQUIREMENTS section of the LCD-related Policy Article (A52464)):Recurrent (more than one) level 2 hypoglycemic events (glucose <54mg/dL (3.0mmol/L)) that persist despite multiple (more than one) 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
	Within six (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 that criteria (1)-(4) above are met

We are pleased to offer the Dexcom G6/G7 CGM System

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

	Dexcom G6/G7 Receiver (A9278/E2103)	**Length of Need**: Lifetime (unless noted otherwise)
	Dexcom Transmitter and Sensors (A9277,A9276/A4239) ◯ 1 Unit (30 day supply) or 30 units (for A4239) ◯ 3 Units (90 day supply) or 90 units (for A4239)	**Length of Need**: Lifetime (unless noted otherwise) **1 Unit = 1 month** of sensors **Note:** Sensor changes are based upon manufacturer guidelines
	GEMCORE360 Transparent Thin Film Dressing, Bag of 10 (included with order)	◯ 2.375" x 2.75" ◯ 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):
_____/_____/_____

Please include clinical notes from last two office visits with order
Please indicate the date of the patient's last office visit below:
_____/_____/_____

☐ 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: