

**\*\*Please attach face sheet w/ patient demographics & insurance info as well as chart notes for visit(s) within the past six months\*\***

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_ Gender:  Male  Female  
Language Pref.:  English  Spanish  Other: \_\_\_\_\_ Emergency Contact Name/Phone Number: \_\_\_\_\_

**DIAGNOSIS**

E 10.9     E 10.65     E 11.9     E 11.65     Other: \_\_\_\_\_

**MEDICAL NECESSITY**

Currently on CGM Therapy?  Yes  No    On an Insulin Pump?  Yes  No    # of Insulin Injections: \_\_\_\_\_/day  
HbA1c: \_\_\_\_\_    Date Last Tested: \_\_\_\_/\_\_\_\_/\_\_\_\_    Fasting Hyperglycemia: \_\_\_\_\_mg/dL    # BG Testing \_\_\_\_\_/day  
Fluctuation of Blood Glucose Values: Low \_\_\_\_\_mg/dL    High \_\_\_\_\_mg/dL

**NEW USER**     **CURRENT USER**     **REPLACEMENT OF DEXCOM RECEIVER**

**SUPPORTING CLINICAL INFORMATION**

- Does the patient have a diagnosis of insulin dependent diabetes mellitus or insulin treated gestational diabetes?  Yes  No
- Does the patient's treatment regimen include at least three insulin injections per day or insulin pump therapy with frequent self-adjustment of insulin doses? (not applicable for gestational diabetes, Type 1 diabetes or rare forms of diabetes)  Yes  No  N/A
- Does the patient have documented blood glucose testing of four or more times per day?  Yes  No
- Has the patient completed a comprehensive diabetes education program?  Yes  No
- Has the patient been evaluated for their diabetes control in the last six months?  Yes  No
- Does the patient have any of the following?
 

<input type="checkbox"/> HbA1c of 7.0% or higher or less than 4.0%	<input type="checkbox"/> Unexplained fluctuations in daily pre-meal glucose levels
<input type="checkbox"/> Early morning fasting hyperglycemia	<input type="checkbox"/> History of severe glycemc excursions
<input type="checkbox"/> Hypoglycemic unawareness, nocturnal hypoglycemia or history of unexplained, severe hypoglycemic events (blood glucose < 50 mg/dL)	<input type="checkbox"/> Recurrent episodes of ketoacidosis or hospitalizations for uncontrolled glucose levels
<input type="checkbox"/> Patient is pregnant and has poorly controlled diabetes or gestational diabetes	
- For replacement Dexcom receivers only:** Is the receiver malfunctioning, no longer under warranty or unable to be repaired?  Yes  No

**PRODUCTS**

Dexcom G6	Abbott FreeStyle Libre	Abbott FreeStyle Libre 2
<input type="checkbox"/> Dexcom G6 Receiver Qty 1 Receiver, A9278, K0554	<input type="checkbox"/> Abbott FreeStyle Libre Reader Qty 1 Transmitter, A9277, K0553	<input type="checkbox"/> Abbott FreeStyle Libre 2 Reader Qty 1 Transmitter, A9277, K0553
<input type="checkbox"/> Dexcom G6 Transmitter Qty 1 Transmitter, A9277, K0553	<input type="checkbox"/> Abbott FreeStyle Libre Sensor Qty 1, Change Sensor Every 14 Days, A9276, K0553	<input type="checkbox"/> Abbott FreeStyle Libre 2 Sensor Qty 1, Change Sensor Every 14 Days, A9276, K0553
<input type="checkbox"/> Dexcom G6 Sensor Qty 1, Change Sensor Every 10 Days, A9276, K0553		

**Order Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Length of Need:**  12 Months  Other: \_\_\_\_\_

**REFERRAL INFORMATION**

**Ref #:** \_\_\_\_\_

Practice Name: \_\_\_\_\_ Fax: \_\_\_\_\_  
Office Address: \_\_\_\_\_ Email: \_\_\_\_\_  
Phone: \_\_\_\_\_ Preferred Method of Contact?  Phone  Fax  Email  
Contact Person: \_\_\_\_\_

Physician Name: \_\_\_\_\_ NPI#: \_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_-\_\_\_\_ Ext. \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*I certify that the above products are medically necessary and that the information provided is accurate to the best of my knowledge. By signing, I acknowledge that I have obtained the patient's authorization to release the above information and other medical information that may be disclosed. I certify that my decision to prescribe this recommended product was solely based on my determination of medical necessity set forth herein. This document may serve as a confirmation of a verbal order and is also recorded in the patient's record.*

Call **1.855.768.3680** or visit **[www.chcsolutions.com](http://www.chcsolutions.com)** for additional information.