brookstone MEDICAL

**Continuous Glucose Monitor (CGM)**
**Detailed Written Order**

117 Hugh Road, Leesburg, GA 31763 | www.brookstonemedical.com

**Phone: (229) 496-6963 | Fax: (229) 516-1387**

## Order Date _____

## Length of Need: 99

**Patient Information**

Name _____ DOB _____ Phone _____

Address _____ Alt. Phone _____

Email _____ Gender _____

Primary Insurance _____ Primary Insurance ID _____

Secondary Insurance _____ Secondary Insurance ID _____

## Equipment Ordered (Please check all that apply)

- ❑ **FreeStyle Libre 3 Reader E2103/K0554**
- ❑ **Dexcom G7 Reader E2103/K0554**
- ❑ **FreeStyle Libre 3 Sensor A4239/K0553**
- ❑ **Dexcom G7 Sensor A4239/K0553**

## Diagnosis (ICD– 10)

❑ E10.9 ❑ E11.65 ❑ E10.65 ❑ E11.8 ❑ E11.9 ❑ Other: _____

## Current Insulin Regimen:

❑ Insulin Pump ❑ Daily Injections (# of): _____ ❑ Daily Inhalations (# of): _____

## Important Coverage Criteria

To be eligible for coverage of a CGM and related supplies, the beneficiary must meet all of the following initial coverage criteria:

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 the criteria below are met:

The beneficiary has diabetes mellitus (applicable diagnoses required); and,

The beneficiary for whom a CGM is being prescribed, to improve glycemic conrol, 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 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

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering items for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the items prescribed.

Prescriber's Name _____ NPI #_____

Prescriber's Signature _____ Date _____

Prescriber's Address _____

Prescriber's Phone _____ Prescriber's Fax _____