

## ORDER FORM – COMMERCIAL INSURANCE Continuous Glucose Monitoring

### PATIENT SECTION

Patient Name		DOB
Phone	Alt Phone	
Shipping Address	City, State, Zip	

### PHYSICIAN SECTION

#### Step 1: Diagnosis Code (required)

E10.9     E11.65     E10.65     E11.8     E11.9     Other: \_\_\_\_\_

#### Step 2: Prescriber's Prescription (strike products NOT prescribed)

A9278 - Receiver (monitor); external, for use with interstitial continuous glucose monitoring system - 1 each

A9277 - Transmitter; external, for use with interstitial continuous glucose monitoring system - 1 unit / 90 days

A9276 - Sensor; disposable, for use with interstitial continuous glucose monitoring system - 1 unit = 1 day supply

\_\_99\_\_ - Length of need in months (99 = lifetime); default is 99 unless specified here: \_\_\_\_\_

#### Step 3: Statement of Medical Necessity (please answer all questions below)

(A) Patient is currently in CGM therapy?     YES     NO

(B) Patient has been seen within the last 6 months?     YES     NO

(C) Patient is treated with insulin injections/inhalation OR is currently on an insulin pump?     YES     NO

↳ If **NO**, does patient have 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

I certify that (1) I am the treating physician of the patient identified in the section above, (2) the information contained herein is true, accurate, and complete to the best of my knowledge and according to my last visit with the patient, (3) I maintain and can provide medical records for the patient that substantiate the information completed above, the patient's ability to use, and medical necessity for a therapeutic continuous glucose monitor and/or related monthly supplies, (4) I agree to provide copies of the supporting medical records, as requested by Aptiva Medical and required by Insurance, (5) the patient requires these products and I have not ordered these same products from another supplier for this patient during this service period, and (6) I certify that Aptiva Medical may contact my patient in regards to products authorized on this document. This document serves as a prescription/order and statement of medical necessity for the above-referenced patient.

Physician Name (print)	NPI #	Phone
Physician Address		Fax

**PRESCRIBER  
SIGNATURE**

**DATE**