DEXCOM ORDER FORM

Certificate of Medical Necessity

For easier processing, please use blue or black ink and use block lettering.

SECTION A: Patient and Prescriber Information

PATIENT INFORMATION

Patient Gender M ☐ F ☐ Height _____ (in.) Weight _____ (lbs.)

Patient Name		Date of Birth
Patient Address		
City	State	Zip
Primary Phone	Patient Email Address	
Dexcom Patient # (for Dexcom use only)	English is my primary language: Yes ☐ No ☐	

PROVIDER INFORMATION

Provider Name		
Provider Address		
City	State	Zip
Primary Phone	Fax	

Check one: ■ NPI # (Required) ☐ DEA # ☐ State License #

SECTION B: Information in this Section may not be Completed by the Supplier of the Items

DIAGNOSIS CODE: ICD-10 Code (Check box) ☐ E10.65 ☐ E10.9 ☐ E11.9 Other _____

STATEMENT OF MEDICAL NECESSITY

Currently on CGM ☐ Yes ☐ No A1C _____ Fasting Hyperglycemia _____ mg/dL

On Insulin Pump ☐ Yes ☐ No #Fingersticks _____ per day #Injections _____ per day Fluctuating of BG Level Low _____ mg/dL High _____ mg/dL

CLINICAL CONSIDERATIONS (Check all that apply)

- ☐ A. Patient administers 3+ injections per day
- ☐ B. Patient self checks BG 4+ times per day
- ☐ C. Patient's insulin treatment requires frequent adjustment by patient on the basis of BGM or CGM testing results.
- ☐ D. History of hypoglycemia unawareness, severed hypoglycemia resulting in third party intervention and/or hospitalization/ paramedical treatment.
- ☐ E. Within 6 months prior to ordering CGM, patient had in-person visit with treating practitioner to confirm that patient is diabetic and meets A-D above and to evaluate patient's diabetes control.
- ☐ F. Patientis motivated and knowledgeable to use CGM, and adheres to a diabetes treatment plan.

PRIMARY/SECONDARY INSURANCE

(or include front and back of patient's insurance card)

Policy Holder Gender M ☐ F ☐

Insurance Name	Policy Holder Name	Policy Holder DOB
Plan Phone Number	Relationship to Policy Holder ☐ Self ☐ Spouse ☐ Child ☐ Other	
ID Number	Rx BIN	
Group Number	Rx PCN	
☐ **Medicare Member ID#**		

SECTION C: Prescription Information

			QUANTITY	REFILLS
Dexcom Receiver	■ 1 Receiver NDC: 08627-0091-11 A9278, K0554	SIG: Use to monitor blood glucose. Displays glucose trends in 3 colors when glucose is high, low or within range.	1	0
Dexcom G5/G6 Transmitter	☐ 1 G5 Transmitter NDC: 08627-0016-01 A9277, K0553 ■ 1 G6 Transmitter NDC: 08627-0016-01 A9277, K0553	SIG: Change transmitter every 3 months. Fastened on top of the sensor and wirelessly sends data to the receiver or compatible smart device. For therapeutic CGM, include all necessary supplies and accessories.	1	3
Dexcom G6 Sensors	■ 1 three-pack Sensors NDC: 08627-0053-03 A9276, K0553	SIG: Change sensor every 10 days. Discreetly worn under clothing and measures glucose levels under skin. For therapeutic CGM, include all necessary supplies and accessories.	1	12
Dexcom G4/G5 Sensors	☐ 1 four-pack Sensors NDC: 08627-0051-04 A9276, K0553	SIG: Change sensor every 7 days. Discreetly worn under clothing and measures glucose levels under skin. For therapeutic CGM, include all necessary supplies and accessories.		

MEDICARE DETAILED WRITTEN ORDER (Complete for Medicare Patients only)

Last office visit:	Order date:				
		■ **Receiver (monitor) K0554**	**SIG: For use with therapeutic Continuous Glucose Monitor System**	1	0
		■ **Supply allowance for therapeutic CGM K0553**	**SIG: Includes all supplies and accessories**	1	99

PLEASE COMPLETE THE PRESCRIPTION INFORMATION ACCORDING TO STATE RULES & REGULATIONS

This document serves as prescription and statement of medical necessity for the above referenced patient for a Dexcom Continuous Glucose Monitoring System (New/Replacement Sensors, Transmitters, and Receivers) and all associated diabetes supplies to be provided by Dexcom or authorized designee.

I certify that I am the prescriber identified in the above section and the medical necessity information contained in this document is true, accurate/complete to the best of my knowledge.

Provider/Authorization Signature: _____ Date _____

Product Selection Permitted

Dispense as Written

 Dexcom Fax #: 844-546-7764

Dexcom, Inc.
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NPI # 1235312695