

# CERTIFICATE OF MEDICAL NECESSITY

|   |  |  |
|---|--|--|
| A9277 Transmitter <input type="checkbox"/> 1/365 days | A9278 Receiver <input type="checkbox"/> 1/365 days | A9276 Sensors <input type="checkbox"/> 90/90 days (1 unit = 1 day) |
|---|--|--|

## PATIENT INFORMATION

|               |             |
|---------------|-------------|
| Patient Name: | Gender:     |
| Address       | DOB:        |
| City/St/Zip   | Phone (day) |

## STATEMENT OF MEDICAL NECESSITY

|                                     |             |                                      |                 |
|-------------------------------------|-------------|--------------------------------------|-----------------|
| # Multiple Daily Injections per day | # SMBG/day  | to                                   | per day         |
| On insulin pump?                    | Start Date: | Fluctuation of blood glucose values: |                 |
| HbA1c:                              | Date:       | Between                              | mg/dl and mg/dl |
| Fasting Hyperglycemia mg/dl         | Date:       | Currently on CGM Therapy?            |                 |

## Dx Code Specific to Complications Associated with Diabetes:

|             |             |
|-------------|-------------|
| ICD-9 Code: | ICD-9 Code: |
|-------------|-------------|

## Current Diabetic Complications:

|  |
|--|
|  |
|  |

## SUPPORTING CLINICAL INDICATIONS

- |  |
|--|
| <input type="checkbox"/> A. History of hypoglycemia unawareness  |
| <input type="checkbox"/> B. History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity and/or very low insulin requirements).                                   |
| <input type="checkbox"/> C. History of nocturnal hypoglycemia  |
| <input type="checkbox"/> D. Recurring episodes of severe hypoglycemia  |
| <input type="checkbox"/> E. Evidence of unexplained severe hypoglycemia episodes requiring external assistance for recovery  |
| <input type="checkbox"/> F. Patient has been hospitalized or has required paramedical treatment for low blood sugar  |
| <input type="checkbox"/> G. Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dl.   |
| <input type="checkbox"/> H. Day-to-day variations in work schedule, mealtimes and/or activity level, which confound the degree of regimentation required to self-manage glycemia with multiple insulin injections. |
| <input type="checkbox"/> I. History of suboptimal glycemic control before or during pregnancy.   |
| <input type="checkbox"/> J. Poor glycemic control as evidenced by 72 hour CGMS sensing trial.  |
| <input type="checkbox"/> K. Multiple alterations in self-monitoring and insulin administration regimens to optimize care   |
| <input type="checkbox"/> L. Patient has completed comprehensive diabetes education   |
| <input type="checkbox"/> M. Patient has demonstrated ability to self-monitor blood glucose levels as recommended by Physician  |
| <input type="checkbox"/> N. Patient is motivated to achieve and maintain improved glycemic control   |

## PHYSICIAN INFORMATION

|                  |                 |
|------------------|-----------------|
| Physician:       | Office Contact: |
| Hospital/Clinic: | Phone #:        |
| Address:         | Fax #:          |
| City/State/Zip:  | NPI #:          |

**This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a DexCom, Inc. SEVEN PLUS Continuous Glucose Monitoring System, SEVEN PLUS sensors, SEVEN PLUS Replacement Transmitter or SEVEN PLUS Replacement Receiver and all associated diabetes supplies to be provided by DexCom or an authorized distributor. NO SUBSTITUTIONS**

I certify that I am the physician identified in the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to Civil or criminal liability.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_