COMMERCIAL

Patient ID #

CERTIFICATE OF MEDICAL NECESSITY

dexcom THE GLUCOSE SENSOR COMPANY

☐ **A9278 Receiver** **Sig: Dispense _1_ Refill _0_** **Use per Manufacturer instructions** **DME ONLY: 1/365 Days**	☐ **A9276 Sensors Quantity 13 boxes Sig: Dispense 1-3 boxes (28-84 day supply) per insurance coverage requirements** **Directions for use: Site change per manufacturer recommendation, up to 90 day supply unless otherwise noted** **DME ONLY: 365/365 (1 unit = 1 day)**
☐ **A9277 Transmitter (3 month use) (G5 model)** **Sig: Dispense _1_ Refill _3_** **Use per Manufacturer instructions 4/365 Days**	☐ **A9277 Transmitter (6 month use) (G4 model)** **Sig: Dispense _1_ Refill _1_** **Use per Manufacturer instructions 2/365 Days**

COMMENTS

PATIENT INFORMATION	**DOB:**
Patient Name:	Address:
Phone:	City/St/Zip:

STATEMENT OF MEDICAL NECESSITY

# Multiple Daily Injections per day		# SMBG/day 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:

Diagnosis Code:	Diagnosis Code:

Current Diabetic Complications:

SUPPORTING CLINICAL INDICATIONS

- ☐ A. History of hypoglycemia unawareness
- ☐ B. History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity and/or very low insulin requirements.
- ☐ C. History of nocturnal hypoglycemia
- ☐ D. Recurring episodes of severe hypoglycemia
- ☐ E. Evidence of unexplained severe hypoglycemia episodes requiring external assistance for recovery
- ☐ F. Patient has been hospitalized or has required paramedical treatment for low blood sugar
- ☐ G. Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dl.
- ☐ 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.
- ☐ I. History of suboptimal glycemic control before or during pregnancy.
- ☐ J. Poor glycemic control as evidenced by 72 hour CGMS sensing trial.
- ☐ K. Multiple alterations in self-monitoring and insulin administration regimens to optimize care
- ☐ L. Patient has completed comprehensive diabetes education
- ☐ M. Patient has demonstrated ability to self-monitor blood glucose levels as recommended by Physician
- ☐ 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. Continuous Glucose Monitoring System, Dexcom, Inc. Sensors, Dexcom, Inc. Replacement Transmitter or Dexcom, Inc. 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.

Signature:______________________________ Date: ____________

LBL-011698 Rev 006 **Fax Toll Free to: 1-877-633-9266 Customer Service: 1-877-DEXCOM4 (339-2664)**