



**Letter of Medical Necessity and Prescription Order**  
**LONG-TERM USE SEVEN® CONTINUOUS GLUCOSE MONITORING SYSTEM**

*This form functions as a Prescription and Letter of Medical Necessity for the Continuous Glucose Monitoring System and all associated diabetes supplies to be provided by DexCom or an authorized distributor.*

Please complete and check all applicable areas:

Patient First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  Male  Female  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Home Phone #: \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

**ICD-9 Code:** \_\_\_\_\_ Prescription duration:  Lifetime need  No substitutions  
 Date of Diagnosis: \_\_\_\_\_ Prescription for HCPCS codes: A9278, Receiver (Monitor), 1/365 days  
 A9277, Transmitter, 1/365 days  
 A9276, Sensors (1 unit=1 day), 90/90 days

**Patient's existing conditions supporting medical necessity for long-term continuous glucose monitoring system:**

- Completed comprehensive diabetes education. Date: \_\_\_\_\_
- Demonstrates compliance with medication, diet, and MD treatment.
- Tests with fingerstick blood glucose \_\_\_\_\_ times daily as documented by log book or meter download.
- MDI/Multiple daily insulin injections: \_\_\_\_\_ injections per day.
- Has an insulin pump. Start date of insulin pump therapy: \_\_\_\_\_
- Experiences hypoglycemia episodes (Less than 50 mg/dl).
- Severe hypoglycemic reactions requiring the assistance of others.
- Unscheduled urgent clinic and/or ER visits to treat significant hypoglycemic episodes.
- Receives care from an endocrinologist or a diabetes specialty clinic.

**Clinical indications for long-term continuous glucose monitoring system:**

- Wide fluctuations in blood glucose values from \_\_\_\_\_ to \_\_\_\_\_ mg/dl
- Hypoglycemia unawareness
- AM hyperglycemia (Dawn Phenomenon)
- Nocturnal hypoglycemia
- Diabetic ketoacidosis
- Neuropathy/nephropathy/retinopathy
- Pre-conception planning
- Fasting hyperglycemia > 150mg/dl
- Inadequate glycemic control despite appropriate adjustments in insulin therapy and compliance with frequent self-monitoring
- Recent A1C value \_\_\_\_\_ % Date of test: \_\_\_\_\_
- Other \_\_\_\_\_

**Please attach documentation supporting the information checked (Log book, meter download, clinical notes, urgent care, emergency room documentation, etc.).**

**Continuous glucose monitoring system training:**

Teaching will be completed by physician and staff  Other trained personnel name: \_\_\_\_\_

Name of Prescribing Physician: (print) \_\_\_\_\_  
 Specialty: \_\_\_\_\_ UPIN: \_\_\_\_\_  
 Office Address: \_\_\_\_\_ NPI: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_  
 Office Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_ Office Contact: \_\_\_\_\_

**Physician Attestation & Signature/Date:**

I certify that I am the physician identified above & have reviewed all of the order information above. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify all the medical necessity information is true, accurate and complete, to the best of my knowledge. The patient's record contains supporting documentation, which substantiates the utilization and medical necessity of the products marked above. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Stamps are not acceptable, signature and date must be handwritten)

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