MEDICARE STANDARD WRITTEN ORDER

FreeStyle Libre 2
FLASH GLUCOSE MONITORING SYSTEM

Instructions

1. Complete all fields on this Standard Written Order.
2. Use the Noridian September 2018 Physician Resource Letter (Continuous Glucose Monitors - Revised) to confirm coverage criteria and medical necessity documentation requirements are met.
3. Fax both this order and the patient's most recent medical records that demonstrate coverage criteria are met to a DME supplier that provides the FreeStyle Libre 2 system.

Patient Information

Patient Name: _____ Date of Birth: _____

Phone: _____ Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Primary Insurance: _____ Primary Insurance Member ID: _____

Secondary Insurance: _____ Secondary Insurance Member ID: _____

Notes: _____

_____

Physician Information

Physician Name: _____ Phone: _____

NPI: _____ Fax: _____

Address: _____ City: _____ State: _____ ZIP: _____

Order Detail

Order Date: _____ / _____ / _____

K0554 (FreeStyle Libre 2 Reader)*	K0553 (FreeStyle Libre 2 Sensors)*
Length of Need: Lifetime - unless specified otherwise: _____	1 Unit/30 Days or 3 Units/90 Days (1 Unit = 1 month of sensor and supplies) - Sensor site changes per manufacturer guidelines Length of Need: Lifetime - unless specified otherwise: _____

Diagnosis (ICD10):

☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.9 ☐ Other: _____

Prescribed Number of Glucose Tests Per Day: _____

Current Insulin Regimen:

☐ Insulin Pump ☐ Multiple Daily Injections - Number Per Day: _____ ☐ Other: _____

I certify that I am the physician identified in the "Physician Information" section above and hereby attest that the medical necessity information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. The patient/caregiver is capable and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Physician Signature: _____ **Date:** _____

As a courtesy to its customers, Abbott provides the most accurate and up-to-date information available, but it is subject to change and interpretation. The healthcare provider is ultimately responsible for determining the appropriate codes, coverage, and payment policies for individual patients. Abbott does not guarantee third party coverage of payment for our products or reimburse customers for claims that are denied by third party payors.

*Per Local Coverage Determination (L33822).
Please see https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=33822&ver=26&DocID=L33822&bc=gAAAAAgAAAAA&#304 for more information.

See Indications and Important Safety Information on reverse.