Valley Mission Homecare Pharmacy
12509 E Mission, Ste 103
Spokane Valley, WA 99216
valleymissionrx.com
Phone (509) 928-6400 **Fax (509) 928-6441**

CONTINUOUS BLOOD GLUCOSE MONITORING (CGM) SYSTEM
Freestyle Libre® 14-day CGM

Tricare Eligibility Assessment & Order Guidance Tool

- **For clinical or technical assistance for the Freestyle Libre®, contact Abbott customer service (855) 632-8658.**
- **This guidance is applicable to Department of Defense/Tricare beneficiaries only. For questions, please call Valley Mission Homecare Pharmacy† at (509) 928-6400.**

STEP 1: Verify the patient's medical condition meets Tricare coverage criteria -- ALL BELOW ARE REQUIRED:

- **Patient has diabetes with ICD-10 codes supporting insulin-requirement**
- **Patient has clinical record documentation of completing a comprehensive diabetic education program**
- **Patient has clinical record documentation showing need for the administration of *at least* 3 daily injections of insulin (or continuous subcutaneous infusion) for glucose control AND the administered dose may vary in part due to current blood glucose measurement (e.g., sliding-scale) with documented occurrences of self-adjusted variability during the previous 3 months. (*Exception*: the 3-month requirement does not apply to gestational diabetes)**
- **Patient has clinical record documentation of blood glucose testing with a traditional, finger-stick method at a frequency of *on average* 4 times daily**
- **One or more of the following must apply:**
  - ☐ **HBA1C level of greater than 7.0% or less than 4.0%**
  - ☐ **history of unexplained large fluctuations in daily glucose values before meals**
  - ☐ **history of early morning fasting hyperglycemia ("dawn phenomenon")**
  - ☐ **history of severe glycemic excursions**
  - ☐ **hypoglycemic unawareness**
  - ☐ **history of recurrent, unexplained, severe hypoglycemic events (i.e. blood glucose less than 50 mg/dl)**
  - ☐ **history of recurrent episodes of ketoacidosis**
  - ☐ **hospitalizations for uncontrolled glucose levels**
  - ☐ **frequent nocturnal hypoglycemia**
  - ☐ **pregnant, with poorly controlled diabetes or gestational diabetes**

STEP 2: Complete all sections of the CGM Detailed Written Order (see page 3)

Continue to next page*

† ***Valley Mission Homecare Pharmacy specializes in the provision of Durable Medical Equipment (DME) and Supplies to many types of beneficiaries including those with Tricare coverage. Information provided here is intended solely to facilitate communication between the Ordering Provider and the DME Supplier to help ensure medical criteria are sufficient for presumptive coverage. This does NOT in any manner replace formal guidance located in the relevant Department of Defense or Tricare coverage manuals.***

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STEP 3: Print and Fax the following documents to (509) 928-6441:

1. **The most recent visit summary pertaining to diabetes management that includes CGM discussion. This must include documentation of required qualifications outlined in STEP 1 above.**
2. **Testing logs demonstrating adherence with 4 times daily testing attempts**
3. **The most recent diabetic-related laboratory report including A1C**
4. **Current medication listing demonstrating at least 3 insulin injections daily with sliding-scale dosing instructions**
5. **Demographic face-sheet for the patient**

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Detailed Written Order

Patient Information

Last Name	First Name	Middle Name	Date of Birth

Physical Address	City	State	Zip Code

Billing Address (if different)	City	State	Zip Code

Phone	Alternate Phone

Prescriber Information

Last Name	First Name	Credential Type	NPI

Practice Location Address	City	State	Zip Code	Tax ID

Practice Location Phone	Practice Location Fax	Supervising Provider Name and NPI if applicable

Order Detail

Rx

- **E2103 Libre CGM Reader Device, Qty #1**
- **A4239 Libre CGM 14-day sensors (1 Unit = 1 month of sensors and supplies), Qty #1 per month**

Length of Need

- **Lifetime – unless otherwise specified**

Diagnosis (ICD-10) – list all codes pertinent to diabetes

Insulin Regimen

Blood Glucose testing frequency and additional instructions

I certify that I am the ordering prescriber specified above and hereby attest that information on this page is true, accurate and complete to the best of my knowledge and that the patient has suitable medical criteria documented in his/her patient record indicating medical necessity for the items listed above. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil or criminal liability. The patient (and his/her caregivers, when applicable) is capable of using this equipment and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Prescriber Signature	Date