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

CONTINUOUS GLUCOSE MONITORING (CGM) SYSTEM
Freestyle Libre® CGM

Eligibility Assessment & Order Guidance Tool

- **For clinical or technical assistance for the Freestyle Libre®, contact Abbott customer service (855) 632-8658.**
- **This guidance is based on requirements for traditional Medicare Beneficiaries. Although other insurers may have less or more stringent requirements - including potential need for prior authorization - CMS policies serve as the reference standard. For questions, please call Valley Mission Homecare Pharmacy† at (509) 928-6400.**

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

- **Patient must have diabetes with a supporting ICD-10 code AND one or more of the following**
  - **Patient is insulin treated, OR**
  - **Patient has a chart-documented history of problematic hypoglycemia with at least two "level 2" hypoglycemic events (glucose less than 54mg/dl) and such events are persisting despite at least two chart-documented attempts to adjust medications or diabetes treatment plan, OR**
  - **Patient has a chart-documented history of problematic hypoglycemia with at least one "level 3" hypoglycemic events (glucose less than 54mg/dl characterized by altered mental/physical state and/or requiring 3rd-party assistance to resolve the episode**
- **Patient has been evaluated for diabetes management either face-to-face or via telehealth within the past 6 months AND has a care plan for ongoing evaluation at least every 6 months.**
- **Chart record for the most recent diabetes evaluation must include clear assessment and indication of medical need for CGM.**
- **Prescriber has determined that the patient (or patient's caregiver) has sufficient training, cognitive and functional ability for effective use of CGM and associated supplies.**

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

STEP 3: Forward the following documents via fax: (509) 928-6441 OR Email: admin@valleymissionrx.com

1. **The most recent face-to-face visit summary pertaining to diabetes management that includes CGM discussion. This must include documentation of required qualifications outlined in STEP 1 above.**
2. **Demographic face-sheet for the patient**

† *Valley Mission Homecare Pharmacy specializes in the provision of Durable Medical Equipment (DME) and Supplies to Medicare beneficiaries. 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 Local Coverage Determination (LCD) specified by the Medicare Administrative Contractor.*

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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 Freestyle Libre *2* CGM Reader Device, or Qty #1**
- **A4239 Freestyle Libre *2* CGM 14-day sensors (1 Unit = 1 month of sensors and supplies), Qty #1 per month**
- **Freestyle Precision Neo blood glucose test strips, Qty #50, for periodic use as "treatment validation" strips for the Freestyle Libre system**

Length of Need

- **Lifetime – unless otherwise specified, diabetes care plan to be reviewed at least every 6 months in a face-to-face visit**

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

Insulin Regimen

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