



CONTINUOUS GLUCOSE MONITORING (CGM) SYSTEM Freestyle Libre® 14-day 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 ICD-10 codes supporting insulin-requirement
- ✦ Patient has been evaluated face-to-face for diabetes management within the past 6 months AND has a care plan for ongoing evaluation at least every 6 months.
- ✦ 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 requires frequent adjustment due to current glucose measurement (e.g., sliding-scale)
- ✦ 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. Current medication listing demonstrating at least 3 insulin injections daily with sliding-scale dosing instructions
3. 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.

**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® 14-day CGM

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	<ul style="list-style-type: none"> ➤ K0554 Freestyle Libre *2* CGM Reader Device, Qty #1 ➤ K0553 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 use as “treatment validation” strips for the Freestyle Libre *2* system
Length of Need	<ul style="list-style-type: none"> ➤ 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
----------------------	------