

ORDER: Implantable Glucose Monitor System

- ☐ **0446T** – Creation of subcutaneous pocket with insertion of implantable interstitial glucose sensor, including system activation and patient training. (Initial insertion, 1 sensor included, performed and billed by health care provider, HCP)
- ☐ **0447T** – Removal of implantable interstitial glucose sensor from subcutaneous pocket via incision. (Billed by HCP)
- ☐ **0448T** – Removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site, insertion of new implantable sensor, including system activation. (Reinsertion, 1 sensor included, performed and billed by HCP)
- ☐ **A9276** – Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system, 1 unit = 1 day supply
- ☐ **A9277** – Transmitter; external, for use with interstitial continuous glucose monitoring system

PATIENT INFORMATION

Patient Last, First Name: _____ Date of Birth: _____

Patient Address: _____ State: _____ Zip: _____

City: _____ Phone: _____

ORDERING HEALTH CARE PROVIDER (HCP)

HCP Last, First Name: _____ NPI#: _____

HCP Address: _____ State: _____ Zip: _____

City: _____ Phone: _____ Fax: _____

MEDICAL NECESSITY*

All shaded areas need to be completed by the HCP to document patient's need for implantable CGM and chart/EMR requirements. Patients who do not meet their insurance plan's medical coverage criteria will be asked to sign a notice of their financial responsibility in advance of the procedure. (e.g. Medicare ABN)

Examples of Diabetes Mellitus (not all inclusive)*:

	Underlying Conditions	T1	T2	Other Specified DM
Hypoglycemia without coma	E08.649	E10.649	E11.649	E13.649
Hyperglycemia	E08.65	E10.65	E11.65	E13.65
Other specified complications	E08.69	E10.69	E11.69	E13.69
Without complications	E08.9	E10.9		E13.9

Fill in:

1. Diagnosis ICD-10-CM _____

Fill in number of Insulin administrations per day:

2. Select Insulin Administration Type:

☐ Pump

☐ Inject # _____

☐ Inhale # _____

3. Fill in:

HbA1c Value: _____

Date of HbA1c: _____

SMBG/Day #: _____

CGM: _____

4. History of hypoglycemia unawareness or recurring episodes of severe hypoglycemia:

☐ YES

☐ NO

5. Patient previously met CGM requirements by Insurer and now elects implantable CGM

☐ YES

☐ NO

6. Patient requires long-term Implantable CGM (more than 72 hours) for diagnostic use:

☐ YES

☐ NO*

7. Are frequent adjustments to insulin treatment required due to glucose monitor test results?:

☐ YES

☐ NO*

8. Patient demonstrates an understanding of technology, is capable of using the device to recognize alerts and alarms, is motivated to use the device correctly and consistently, is willing to commit to clinical visits as needed for sensor replacement, and is expected to adhere to comprehensive diabetes treatment plan.

☐ YES

☐ NO*

9. What was last date of in-person visit with treating health care provider (within last 6 months):

DATE: _____

10. Routine follow-up care is expected within (fill in date, number of weeks, number of month(s), etc.):

PRIOR AUTHORIZATION REVIEW

☐ Urgent Review

If checked, must include rationale to justify patient need for urgent request

HEALTH CARE PROVIDER ATTESTATION

This document serves as an Order and Statement of Medical Necessity for the above referenced patient for a THERAPEUTIC IMPLANTABLE CONTINUOUS GLUCOSE MONITORING SYSTEM: Sensor, Smart Transmitter, all associated Eversense CGM system components and all associated diabetes supplies to be provided by an authorized distributor. I certify that I am the health care provider identified in the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge. By signing you agree that your Eversense patient has consented to allow third parties to receive their health information to provide benefits verification and allow Ascensia to contact the patient to support the benefits verification, and any other matters relevant to the patient getting started on therapy.

HEALTH CARE PROVIDER SIGNATURE: _____

DATE: _____

*The medical necessity criteria used in this form was based on CMS LCDs for Implantable Continuous Glucose Monitoring (accessed 06/14/23). Other insurer requirements may vary by plan.

Fax completed form to: _____