ORDER FOR: Therapeutic Implantable Continuous Glucose Monitoring

Order to be completed by Ordering Health Care Provider (HCP) in its Entirety

ORDER: Implantable Glucose Monitor System

☐ Sensor; invasive (e.g., subcutaneous), disposable, for use with interstitial continuous glucose monitoring system - Dispensing qty 1 = 365 days.

☐ Transmitter; external, for use with interstitial continuous glucose monitoring system - Dispensing qty 1. Replaced annually.

Eversense 365 CGM System (sensor and transmitter) - use as directed. Sensor to be inserted subcutaneously at the doctor's office.* Replaced annually.

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	E11.9	E13.9

1. Diagnosis ICD-10-CM	**Fill in:**			
2. Select Insulin Administration Type:	☐ **Pump**	☐ **Inject #** _____ **Fill in number of Insulin administrations per day:**		
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.)*:		

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:** _____

* Sensor placement may occur in other settings besides a healthcare provider's office.

** The medical necessity criteria used in this form was based on CMS LCDs for Implantable Continuous Glucose Monitoring 8/14/24 LCD - Implantable Continuous Glucose Monitors (I-CGM) (L38623). (accessed 4/25/25) Other insurer requirements may vary by plan.

Fax completed form to: _____