eversense® Continuous Glucose Monitoring System | ASCENSIA Diabetes Care

# 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

- ☐ **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 |

**1.** Diagnosis ICD-10-CM — **Fill in:**

**2.** Select Insulin Administration Type: ☐ **Pump** ☐ **Inject #** _____ ☐ **Inhale #** _____ — **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.)*: | | |

## 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:** _____