Patient Information Form

EVERSENSE® E3 CGM ORDER
FAX TO: 1-973-201-0553 EMAIL TO: EVERSENSEENROLLMENT@ASCENSIA.COM

PROVIDER INFORMATION

Prescribing HCP Name: _____ NPI: _____

Fax: _____ Email: _____ Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Inserting HCP Name: _____ NPI: _____

Fax: _____ Email: _____ Phone: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Patient Name: _____ DOB: _____

Mobile Phone: _____ Email: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance: _____ Phone: _____

Member #: _____ Group#: _____ Subscriber: _____

Secondary Insurance: _____ Phone: _____

Member #: _____ Group#: _____ Subscriber: _____

Previous CGM:	☐ **YES**	☐ **NO**	☐ Dexcom:	☐ Medtronic:	☐ Abbott:

Diagnosis Code — IDC10: _____

TO PRESCRIBER:

I hereby ORDER/PRESCRIBE the following Eversense CGM products (as applicable) for the patient identified above: Eversense® E3 Sensor, Eversense E3 Transmitter and Adhesive Patches, and Eversense® Insertion Tool Kit. After consultation with the above patient, reviewing his/her medical history, and evaluating his/her diagnoses and care plan, I represent that the information contained herein is accurate and the products being ordered are reasonable and medically necessary for this patient.

I attest that the patient understands he/she is being prescribed the Eversense® E3 CGM System, and agrees to use the System in accordance with their prescription, treatment plan, and Eversense® E3 product instructions. To facilitate this order, receive appropriate training, and be eligible for customer support, the patient consents to his/her personal and health information being shared with Senseonics, Incorporated, its authorized agents, its authorized third party service providers, and/or a Senseonics-contracted sales or distribution company including Ascensia Diabetes Care.

As necessary conditions for utilizing Eversense® E3, I also attest that the patient meets the following criteria: (i) has a smartphone; (ii) takes insulin; (iii) is willing to calibrate their glucose sensor up to 2 times per day; and (iv) understands an office procedure will be required every 180 days (or the applicable wear period per the specific Eversense product) for the insertion and/or removal of the Eversense® E3 sensor.

By signing below, I certify that I have obtained a valid HIPAA authorization form from the patient authorizing me to release the patient's protected health information to Ascensia Diabetes Care, and authorizing Ascensia Diabetes Care to share this patient's information with its authorized third party service providers, as necessary to obtain insurance coverage, payment information and assistance, and reimbursement information for any of the Eversense® E3 products listed above. As necessary, Senseonics or a contracted partner will contact the patient by phone text or email to further the order and provide reimbursement and payment information.

By signing below, I certify that I have read and agree to statements above.

☐ I hereby attest that the patient agrees to receive marketing communications (by phone, text and/or email) from Senseonics Inc. on its products, events and promotions in accordance with Senseonics' privacy policy
https://www.ascensiadiabetes.com/eversense/privacy-policy

☐ I hereby attest that the patient agrees to receive marketing communications (by phone, text and/or email) from Ascensia Diabetes Care US and its affiliates on their products, events and promotions in accordance with Ascensia's privacy policy
https://www.ascensiadiabetes.com/privacy-statement

Physician Signature: **Date:**

(Please retain a copy of this signed document in the patient's medical record.)

PLEASE COMPLETE NEXT PAGE

TO PATIENT:

By signing this authorization, I, the patient, authorize my healthcare provider to use and/or disclose my protected health information (PHI) related to the **Eversense® E3 Sensor, Eversense E3 Transmitter and Adhesive Patches, and/or Eversense® Insertion Tool Kit** from my health records and insurance information to Senseonics, Inc. and I further authorize Senseonics to share this information with its authorized agents, its authorized third party service providers, and/or a Senseonics contracted sales or distribution company, including Ascensia Diabetes Care, as necessary for treatment and care coordination, and to obtain insurance coverage and reimbursement information for the Eversense® E3 Sensor, Eversense® E3 Transmitter and Adhesive Patches, and/or Eversense® Insertion Tool Kit. Senseonics and/or its authorized agents may share my information with its contracted distribution and/or fulfillment partners, to facilitate the order. As necessary, Senseonics and/or its contracted partners may contact me (by phone, text and/or email) to further the order and provide reimbursement and payment information. I understand that the information I authorize a person or entity to disclose may be shared with other people or entities and will no longer be protected by federal privacy regulations. In carrying out these activities, Senseonics and/or its authorized third party service providers may relay information to health insurer(s), receive information from health insurer(s), and communicate such information to my healthcare provider. I understand that this authorization is voluntary and that I may refuse to sign this authorization. If I do so, I understand that Senseonics will not be able to provide the service related to the Eversense® E3 Sensor, Eversense® E3 Transmitter and Adhesive Patches, and/or Eversense® Insertion Tool Kit. I understand that my refusal to sign does not affect payment for services, my ability to obtain treatment, or my eligibility for benefits or enrollment. I understand that I may revoke this authorization at any time provided that the information has not been disclosed. Information that has already been disclosed may be further disclosed once the authorization has been revoked. I understand that if I choose to revoke this authorization, I must do so in writing to the following email address **eversenseenrollment@ascensia.com** or by calling customer service at 1-844-736-7348 available from 8:00AM – 12:00AM ED Monday to Sunday. This authorization will remain in effect until revoked by me or until the end of my participation in the program.

I, _____ (Print Full Legal Name), have read and agree with the above terms and conditions for my Eversense® CGM order.

☐ I wish to receive marketing communications (by phone, text and/or email) from Senseonics Inc. on its products,events and promotions in accordance with Senseonics' privacy policy **https://www.ascensiadiabetes.com/eversense/privacy-policy/**.

☐ I wish to receive marketing communications (by phone, text and/or email) from Ascensia Diabetes Care USand its affiliates on their products, events and promotions in accordance with Ascensia's privacy policy **https://www.ascensiadiabetes.com/privacy-statement/**. You can opt out any time e.g. by replying STOP to a text, or calling ADC at 1-844-736-7348.

Physician Signature: **Date:**