KGD
Ken Glover Drug

Fax Completed Document to: (205) 648-9644

DETAILED WRITTEN ORDER Continuous Glucose Monitoring

PATIENT_____DOB _____

START DATE IF OTHER THAN DATE SIGNED_____ LENGTH OF NEED:12 MONTHS

ICD-10 DIAGNOSIS CODE_____

DATE OF LAST OFFICE VISIT:_____

PROCEDURE CODE: A9276/A4239/K0553, A9277/A4239/K0553, A9278/E2103/K0554

☐ Freestyle Libre 2 ☐ Dexcom G6

ITEM TO BE DISPENSED:may be dispensed in 90 day supply or insurance max limit

A9276/A4239/K0553 CGM Sensors x 1 Box x PRN refills may be dispensed in 90 day supply Change dexcom sensor every 10 days /Libre sensor every 14 days

A9277/A4239/K0553 CGM transmitter x 1/90 days x PRN refills
Change as directed per manufacturer

A9278/E2103/K0554 Receiver x 1/365 days x PRN refills
For use with CGM sensors

A4253/Test Strips #1 box X PRN Refills A4259 /Lancets #1 box X PRN refills

_____**Complete all areas below:****_____**

On Insulin Pump:___yes___no Currently on CGM Therapy:__yes___no HbA1c:_____

Patient takes _____# of insulin shots per day (ex: 0-3+) Brand of Insulin pt is on:_____

Fluctuation of Blood Glucose :Low_____ mg/dl High_____mg/dl

Patient checks blood sugar 4 or more times a day: ____yes ____no # of daily blood glucose checks_____

PHYSICIANS SIGNATURE_____product selection permitted / DATE_____

PHYSICIAN PRINTED NAME_____ NPI_____

Fax Back with copy of last clinical note and demographic sheet to 205-648-9644 KGD 12/22