**Certificate of Medical Necessity:**

**Continuous Glucose Monitoring Supplies (CGM) Medicaid Letter**

|  |  |
| --- | --- |
| Date |  |
| Patient Name |  |
| Date of Birth |  |

We are seeking to continue to better manage this patient's diabetes by using:

□ FreeStyle Libre (14-day or Libre 2) continuous glucose monitor system

□ DexCom G6 continuous glucose monitor system

□ Eversense continuous glucose monitor system

□ Medtronic Guardian continuous glucose monitor system

This patient:

|  |  |
| --- | --- |
| □ | Self-monitors blood glucose a minimum of 3 times per day |
| □  □ | Uses an insulin pump or MDI a minimum of 3 times per day or administers insulin continuously via pump  Requires frequent adjustment of insulin dosage |
| □ | Has received education specific to the use of therapeutic CGM |
| □ | Is able to hear & view the CGM alerts and respond accordingly, or has a caregiver able to do so |
| □ | Had an in-person or telehealth visit within the last 6 months with the treating clinician to evaluate diabetes control |
| □ | Provider has verified the patient meets the manufacturer's recommendations for appropriate age range, testing and calibration requirements, etc. |
| □ | Or patient has otherwise qualifying circumstances or otherwise deemed medically necessary |

The patient and I are requesting these continuous glucose monitoring supplies be approved to continue to help improve their glycemia and thus their long-term quality of life as someone diagnosed with diabetes.

Clinician Name (Printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Clinician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_