


EQUIPMENT TO PRESCRIBE (please complete all fields below)

| | | | |
|---|---|--|---|
| <input type="checkbox"/> FreeStyle Libre reader & sensors |  | <input type="checkbox"/> Dexcom reader & sensors |  |
| Dispense: FREESTYLE LIBRE <ul style="list-style-type: none"> E2103 - receiver (monitor), dedicated, for use with therapeutic CGM system A4239 - monthly supply allowance for therapeutic CGM (includes up to 3 units supply per 90 days) | | Dispense: DEXCOM <ul style="list-style-type: none"> E2103 - receiver (monitor), dedicated, for use with therapeutic CGM system A4239 - monthly supply allowance for therapeutic CGM (includes up to 3 units supply per 90 days) | |
| Does the patient currently use a CGM reader? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, Circle appropriate product from list below: FreeStyle Libre 14day FreeStyle Libre 2 FreeStyle Libre 3 Dexcom G6 Dexcom G7 | | | |

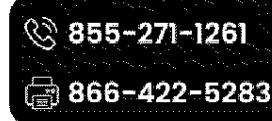
STANDARD WRITTEN ORDER (SWO) (please complete all fields below)

| | | |
|----------------------------|-----------------------------|-----------------------|
| Patient Name: Steve Tester | Patient Address: | Patient DOB: 1/1/1980 |
| Patient Phone: | Primary Insurance Company: | Member ID: |
| Length of need: LIFETIME | Secondary Insurance Company | Member ID: |

4 Easy Steps for Prescribing a Continuous Glucose Monitor (CGM)

By following these steps, you can ensure a smooth process for prescribing a CGM for your patients.

1. **Beneficiary is insulin using with diabetes Mellitus**
2. Submit supporting medical records - signed and dated:
 - Include a diabetic office visit note from within the last 6 months of this Rx.
3. Ensure clarity : Handwritten items must be legible (name, date, signature, etc.)
4. Correct carefully : Initial and date any corrections made on the form.

Where to send the RX and Documents

PROVIDER INFORMATION (please complete all fields below)

| | |
|-----------------------------|--------|
| Provider Name: Steve Faxter | Fax: |
| NPI: | Phone: |
| Provider Email: | |

Provider Signature: _____

Date: _____

I HAVE REVIEWED THE PRESCRIPTION ABOVE AND FOUND THE INFORMATION TO BE ACCURATE.
I CERTIFY THE MEDICAL NECESSITY TO FACILITATE MANAGEMENT OF THIS PATIENT'S DIAGNOSIS.
THIS PRESCRIPTION ACCURATELY REFLECTS THE PATIENT'S CONDITION, & IS SUBSTANTIATED BY MEDICAL RECORDS.

Account Executive

info@questheathsolutions.com | www.questheathsolutions.com | 7401 Wiles Road, Suite 139 Coral Springs, FL 33067

