ARTHEON MEDICAL

Order Date:

PATIENT INFORMATION

First: _____ Middle: _____ Last: _____ DOB: _____ Gender: ☐ M ☐ F

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

Phone: _____ Sec. Phone: _____ Email: _____

Insurance Name: _____ ID Number: _____

ITEMS TO BE DISPENSED

Diagnosis (ICD10): ☐ E10.9 ☐ E11.65 ☐ E10.65 ☐ E11.8 ☐ E11.39 ☐ Other: _____

IS PATIENT INJECTING INSULIN? ☐ **YES** ☐ **NO** **HISTORY OF PROBLEMATIC HYPOGLYCEMIA?** ☐ **YES** ☐ **NO**

Recurrent (more than one) level 2 hypoglycemic events ☐ **OR** **History of one level 3 hypoglycemic event** ☐

CGM:

☐ Freestyle Libre 2 +

Reader:
Use with Sensor to monitor blood glucose

Dispense:
One Reader/ 365 days
1 refill/ year

Sensors:
Change sensors every 15 days

Dispense:
Six Sensors/ 98 days
4 refills/ year

☐ Freestyle Libre 3 +

Reader:
Use with Sensor to monitor blood glucose

Dispense:
One Reader/ 365 days
1 refill/ year

Sensors:
Change sensors every 15 days

Dispense:
Six Sensors/ 98 days
4 refills/ year

☐ FreeStyle Libre 14

Sensors:
Change sensors every 14 days

Dispense:
Seven Sensors/ 98 days
4 refills/ year

☐ Dexcom G7

Reader:
Use with Sensor to monitor blood glucose

Dispense:
One Reader/ 365 days
1 refill/ year

Sensors:
Change sensors every 10 days

Dispense:
Nine Sensors/ 90 days
4 refills/ year

Physician Signature: _____ **Date** _____

SIGNATURE AND DATE STAMP NOT ACCEPTED

Physician Name: _____ **NPI#:** _____

Please Fax to: **(813) 367 -1131**