STAR DME
Medical & Surgical Supply

Star DME Inc.
141–04 Rockaway Blvd, Suite 1F, Jamaica, NY 11436
Fax 844–438–5893 · Ph 917–300–2692
stardme.com

Standard Written Order (SWO)

CGM · FREESTYLE LIBRE SYSTEM

INSTRUCTIONS

1. Complete all fields on this Standard Written Order (SWO).
2. Fax to DME supplier **844–438–5893** both this order and the patient's most recent **medical records** that demonstrate coverage criteria are met.

Patient Information

Name _____ **DOB** _____

Address _____

Phone _____ **Cell** _____

Primary Insurance _____ **ID#** _____

Secondary Insurance _____ **ID#** _____

Items Ordered

☐ **E2103 (FreeStyle Libre Reader)**
1 Reader/1095 Days
Length of need: Lifetime – unless specified otherwise:
_____

☐ **A4239 (FreeStyle Libre Sensor)**
1 Unit/30 Days (1 Unit = 1 month of sensors and supplies)
Length of need: Lifetime – unless specified otherwise:
_____

DIAGNOSIS

- ☐ E10.9 Type 1 diabetes mellitus without complications
- ☐ E10.65 Type 1 diabetes mellitus with hyperglycemia
- ☐ Other: _____
- ☐ E11.65 Type 2 diabetes mellitus with hyperglycemia
- ☐ E11.8 Type 2 diabetes mellitus with unspecified complications
- ☐ E11.9 Type 2 diabetes mellitus without complications
- ☐ Other: _____

CURRENT REGIMEN

- ☐ The beneficiary is insulin-treated; OR,
- ☐ The beneficiary has a history of problematic hypoglycemia with documentation of at least one of the following:
  - ☐ Recurrent (more than one) level 2 hypoglycemic events (glucose <54 mg/dL (3.0 mmol/L)) that persist despite multiple (more than one) attempts to adjust medication(s) and/or modify the diabetes treatment plan; or,
  - ☐ A history of one level 3 hypoglycemic event (glucose <54 mg/dL (3.0 mmol/L)) characterized by altered mental and/or physical state requiring third-party assistance for treatment of hypoglycemia.

Physician Information

I certify that I am the physician identified in the "Physician Information" section below and hereby attest that the medical necessity information is true, accurate, and complete to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to administrative, civil, or criminal liability. The patient/caregiver is capable and has successfully completed or will be trained on the proper use of the products prescribed on this order.

Physician's Signature _____ **Name** _____

NPI # _____ **Date** _____

Signature and date stamps are not acceptable.