

## Certificate of Medical Necessity Continuous Glucose Monitoring (CGM) System

### PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Email (optional): \_\_\_\_\_

### STATEMENT OF MEDICAL NECESSITY

Diabetes Type:  Type 1  Type 2  Gestational  
Diabetes Therapy:  Multiple Daily Injections (\_\_\_\_\_ injections per day)  
 SMBG tests (\_\_\_\_\_ tests per day)  
 Insulin pump - (start date: \_\_\_\_/\_\_\_\_/\_\_\_\_)  
 Compliance with prescribed dietary and insulin regimens

### OPTIONAL

HbA1c results only required  
for some insurance providers:  
Manulife, OTIP, Johnson  
Insurance, and Manion Wilkins.

HbA1c Result #1: \_\_\_\_\_ Date: \_\_\_\_\_  
HbA1c Result #2: \_\_\_\_\_ Date: \_\_\_\_\_  
HbA1c Result #3: \_\_\_\_\_ Date: \_\_\_\_\_

### SUPPORTING CLINICAL INDICATIONS

- Motivated to achieve and maintain improved glycemic control
- Demonstrated ability to self-monitor blood glucose levels
- Demonstrated ability to self-manage glucose using insulin (long acting, fast acting)
- History of hypoglycemia unawareness
- History of severe glycemic excursions
- History of nocturnal hypoglycemia
- Recurring episodes of severe hypoglycemia
- Unexplained, severe hypoglycemia episodes requiring external assistance for recovery
- Other: \_\_\_\_\_

### PHYSICIAN INFORMATION

Physician Name: \_\_\_\_\_ Office Contact: \_\_\_\_\_  
Hospital/Clinic Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
Email (optional): \_\_\_\_\_

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a Dexcom Continuous Glucose Monitoring (CGM) System, Dexcom CGM Sensors, Dexcom CGM Replacement Transmitter or Dexcom CGM Replacement Receiver and all associated diabetes supplies to be provided by Dexcom Canada, Inc. NO SUBSTITUTIONS.

I certify that I am the physician identified in the above section and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to Civil or criminal liability.

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

Please return by email to [CA.Sales.dc@Dexcom.com](mailto:CA.Sales.dc@Dexcom.com), by toll free fax to 1-844-348-0784  
or by regular mail to: Dexcom Canada, Inc. 501 – 4445 Lougheed Hwy, Burnaby, BC V5C 0E4