

**1.**

**PATIENT INFORMATION**

Full Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone Number: \_\_\_\_\_  New  Supply Refill

Patient Recent Weight (lbs.): \_\_\_\_\_ Total Daily Insulin (TDI): \_\_\_\_\_ A1C: \_\_\_\_\_

DIAGNOSIS CODE: ICD-10 Code  E10.65  E10.9  E11.9  E11.65  O24.41 (for G7 only)

Other: \_\_\_\_\_

**2. Dexcom CGM - PRESCRIPTION INFORMATION** 

**Dexcom**

**FreeStyle Libre**

**G6** Receiver / Sensor / Transmitter  
 **G7** Receiver / Sensor / Transmitter (Integrated)  
 **G7 (15 Days)** Receiver / Sensor / Transmitter (Integrated)  
\*Not compatible with Tandem Aid System

**2 Plus** Receiver / Sensor / Transmitter  
\*Not compatible with Tandem Mobi nor iLet Aid System

**3 Plus** Receiver / Sensor / Transmitter (Integrated)  
\*Not compatible with Mobi Aid System

Applicable refills for any of the CGM:  3 months  6 months  12 months

**3. AID SYSTEM - PRESCRIPTION INFORMATION**



**t:slim X2**

**Mobi**



**Infusion Set Type:**

AutoSoft XC  AutoSoft 30  AutoSoft 90  TruSteel  VariSoft

\*Tandem PSO - At training, weight/TDI to be used in Profile Settings Calculator (MDI) or transfer of existing pump settings (IPT) unless box below is checked.

Prescriber to provide pump settings on PSO. Box must be checked if using non-U-100 analog insulin in pump.



**Infusion Set Type:**

Contact Detach: Steel Cannula  
 Inset: Soft Cannula 6mm

AID System, Cartridge & Infusion Set Change Every:

3 (qty 30)  2.25 (qty 40)  2 (qty 50)  1 (qty 90)

Applicable refills of any of the AID systems:  3 months  6months  12 months

**4. QUALIFICATIONS AND INDICATIONS AS PER MEDICAL RECORDS (CHECK ALL THAT APPLY)**

Patient/caregiver has the ability to operate and can use an insulin pump to manage blood glucose  
 Patient treated with insulin and or have documented level 2 or level 3 hypoglycemic events.  
 Multiple Daily Injections 3-4 times per day with self-adjustments to insulin doses.  
 Current Insulin Pump is out of warranty, or its functionality no longer meets the patient's medical need.  
 Patient is pregnant or planning pregnancy.

**Notes:**

**5.**

**PRESCRIBER INFORMATION**

**Prescribing Provider / Physician Countersignature (If Applicable) Attestation and Signature/Date**

I certify that I am the prescribing provider identified above and have reviewed all the order information above. Any statement on my letterhead attached hereto has been reviewed and signed by me. I certify all the medical necessity information is true, accurate and complete, to the best of my knowledge. The patient's record contains supporting documentation, which substantiates the utilization and medical necessity of the products marked above.

Provider Name: \_\_\_\_\_ NPI# \_\_\_\_\_ PR Lic # \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Fax: \_\_\_\_\_

**PRESCRIBING PROVIDER SIGNATURE (SIGNATURE STAMPS ARE NOT ACCEPTABLE)**

DATE:

**6. PHYSICIAN'S COUNTERSIGNATURE - IF APPLICABLE**

**PHYSICIAN COUNTERSIGNATURE - IF APPLICABLE (SIGNATURE STAMPS ARE NOT ACCEPTABLE)**

DATE: