

PRESCRIPTION ORDER

CONFIDENTIAL HEALTH INFORMATION



1. PATIENT INFORMATION

Full Name: _____ Date of Birth:
MM DD YYYY
Phone Number: _____ New Supply Refill
Patient Recent Weight (lbs.): _____ Total Daily Insulin (TDI): _____ AIC: _____
DIAGNOSIS CODE: ICD-10 Code E10.65 E10.9 E11.9 E11.65 O24.41 (for G7 only)
Other: _____

2. dexcom CGM - PRESCRIPTION INFORMATION FreeStyle

<p>Dexcom</p> <p><input type="checkbox"/> G7 Receiver / Sensor / Transmitter (Integrated)</p> <p><input type="checkbox"/> G7 (15 Days) Receiver / Sensor / Transmitter (Integrated) <i>*Not compatible with Tandem Aid System</i></p>	<p>FreeStyle Libre</p> <p><input type="checkbox"/> 2 Plus Receiver / Sensor / Transmitter <i>*Not compatible with Tandem Mobi nor iLet Aid System</i></p> <p><input type="checkbox"/> 3 Plus Receiver / Sensor / Transmitter (Integrated) <i>*Not compatible with Mobi Aid System</i></p>
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Applicable refills for any of the CGM: 3 months 6 months 12 months

3. AID SYSTEM - PRESCRIPTION INFORMATION

<p> <input type="checkbox"/> t:slim X2 <input type="checkbox"/> Mobi</p> <p>Infusion Set Type:</p> <p><input type="checkbox"/> AutoSoft XC <input type="checkbox"/> AutoSoft 30 <input type="checkbox"/> AutoSoft 90 <input type="checkbox"/> TruSteel <input type="checkbox"/> VariSoft</p> <p><small>*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.</small></p> <p><input type="checkbox"/> Prescriber to provide pump settings on PSO. Box must be checked if using non-U-100 analog insulin in pump.</p>	<p>Beta Bionics <input type="checkbox"/> iLet</p> <p>Infusion Set Type:</p> <p><input type="checkbox"/> Contact Detach: Steel Cannula</p> <p><input type="checkbox"/> Inset: Soft Cannula 6mm</p>
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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 6 months 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.

The patient is currently using a CGM and uses it appropriately to manage their diabetes.

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:
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6. PHYSICIAN'S COUNTERSIGNATURE - IF APPLICABLE

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

	DATE:
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