PRESCRIPTION ORDER

CONFIDENTIAL HEALTH INFORMATION

nazareno DIABETES CARE

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

Dexcom

☐ G7 Receiver / Sensor / Transmitter (Integrated)

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

FreeStyle Libre

☐ 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

TANDEM Diabetes Care ☐ 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.

Beta Bionics ☐ iLet

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 ☐ 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:

6. PHYSICIAN'S COUNTERSIGNATURE - IF APPLICABLE

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

	DATE:

EMAIL COMPLETED FORM TO: **RX@NAZARENOLLC.COM**

THIS ORDER IS SUBJECT TO HEALTH PLAN APPROVAL