nazareno DIABETES

(787) 740-2934

SUPPLIES PRESCRITION ORDER

dexcom

TANDEM Diabetes Care

PATIENT ORDER INFORMATION

NAME:		DATE	
ADDRESS	CITY:	State: P.R.	Zip Code:

Diagnosis Code/ICD-10 Code ☐E10.65 ☐E10.9 ☐E11.9 ☐ E11.65 ☐ O24.41 for G7 only Other:

TANDEM T: SLIM X2 - INSULIN PUMP SUPPLIES

A) Infusion Set model:

☐ **AutoSoft XC** 90-degree Flexible Soft Cannula

☐ **AutoSoft 30** 30-degree Flexible Soft Cannula

☐ **TruSteel** 90-degree Stainless Steel Needle

☐ **AutoSoft 90** 90-degree Flexible Soft Cannula

☐ **VariSoft** Variable Insertion Angle (20°- 45°) Soft Cannula

B Infusion set change frequency: ☐ Every 3 day (Qty.30) ☐ Every 2 day (Qty.50)

C) 3mL Cartridge change frequency: ☐ Every 3 day (Qty.30) ☐ Every 2 day (Qty.50)

D) Refill times _____

DEXCOM G6 / G7 CGM SUPPLIES

G6

☐ Sensors: **A9276**

☐ Transmitter: **A9277**

Refill: _____ Applies for: Vital, Commercial and Triple S Advantage Health Plans

G7

☐ Sensors: **A9276**

☐ Transmitter: **A9277**

Refill: _____ Applies for: Vital, Commercial and Triple S Advantage Health Plans

MEDICARE ADVANTAGE *** *Important: This form does not apply for Medicare Original (Tradicional)*

☐ **A4239** - Sensor / Transmitter

☐ **G6** ☐ **G7**

Refill: _____

PHYSICIAN INFORMATION

Physician Name:	Phone #:

I certify that I am the prescribing provider identified above and have reviewed all of the order information above. Any statement on my letterhead attached here to, 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. I understand the indications for use and associated warnings and precautions of the products I have prescribed here in. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Physician Signature X	PR Lic #	NPI #
VITAL PCP Signature (if apply) X	PR Lic #	NPI #

Please send completed to: ***suplidos@nazarenollc.com*** or fax to (787) 288-0704

This order is subject to your Health Plan Approval