nazareno DIABETES

PRESCRIPTION ORDER

** Confidential Patient Health Information **

dexcom

TANDEM Diabetes Care

1 PATIENT ORDER

Name:	DOB: Phone #:	☐ New Patient ☐ Supplies Refill

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

2 PRESCRIPTION INFORMATION

☐ **Dexcom G7 & Supplies/**Receiver (use as directed) | Sensors / Transmitter (change sensor every 10 days)

☐ **Dexcom G6 & Supplies/**Receiver (use as directed) |Transmitter (every 90 days) |Sensors qty 9 (sensor every 10 days)

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

TANDEM Insulin Pump with Control-IQ™ Technology & Supplies (Infusion Sets)

☐ **Tandem Mobi System**

☐ **t: slim X2™**

CARTRIDGE & INFUSION SET CHANGE EVERY ____ DAYS (REQUIRED) ☐ **3 (qty 30)** ☐ **2.25 (qty 40)** ☐ **2 (qty 50)** ☐ **1 (qty 90)**

a) Infusion Set Type: ☐ **AutoSoft XC** ☐ **AutoSoft 30** ☐ **TruSteel** ☐ **AutoSoft 90** ☐ **VariSoft**

b) Refill times _____

☐ Patient/Caregiver completed a comprehensive diabetes program & educated in diabetes management (including carbohydrate counting)

3 QUALIFICATIONS AND INDICATIONS AS PER MEDICAL RECORDS (CHECK ALL THAT APPLY):

☐ 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.

Note:

4 PRESCRIBER PHYSICIAN INFORMATION

Prescribing Provider Name		NPI#	PR Lic #:
Address:			Phone:
City:	State: PR	Zip:	Fax:

Prescribing Provider 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. 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. A copy of this order will be retained as part of the patient's medical record.

WARNING: Control-IQ technology should not be used by anyone under the age of 6 years old. It should also not be used in patients who require less than 10 units of insulin per day or who weigh less than 55 pounds.

PRESCRIBING PROVIDER SIGNATURE (SIGNATURE STAMPS ARE NOT ACCEPTABLE)	DATE

Email completed form to: rx@nazarenollc.com

This order is subject to your Health Plan Approval