

PRESCRIPTION ORDER

Confidential Patient Health Information



1	PATIENT ORDER INFORMATION		
Patient Name:		DOB: <small>(mm/dd/yyyy)</small>	<input type="checkbox"/> New <input type="checkbox"/> Supplies Refill
		Phone #:	
*Patient recent weight (lbs.) _____		*Total Daily Insulin (TDI) _____	A1C : _____
DIAGNOSIS CODE: ICD-10 Code <input type="checkbox"/> E10.65 <input type="checkbox"/> E10.9 <input type="checkbox"/> E11.9 <input type="checkbox"/> E11.65 <input type="checkbox"/> O24.41 (for G7 only) Other: _____			

2	DEXCOM	PRESCRIPTION INFORMATION	FreeStyle
Dexcom <input type="checkbox"/> G6 <input type="checkbox"/> G7		FreeStyle Libre <input type="checkbox"/> 2 Plus * Not compatible with iLet Aid System <input type="checkbox"/> 3 Plus * Not compatible with any Tandem Aid System	
Applicable refills for any of the CGM: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months			
 <input type="checkbox"/> t: slim X2™ <input type="checkbox"/> Tandem Mobi Infusion Set Type: <input type="checkbox"/> AutoSoft XC <input type="checkbox"/> AutoSoft 30 <input type="checkbox"/> AutoSoft 90 <input type="checkbox"/> TruSteel <input type="checkbox"/> VariSoft		Beta Bionics <input type="checkbox"/> iLet Infusion Set Type: <input type="checkbox"/> Contact Detach: Steel Cannula <input type="checkbox"/> Inset: Soft Cannula 6mm	
* 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. <input type="checkbox"/> Prescriber to provide pump settings on PSO. Box must be checked if using non-U-100 analog insulin in pump.			
AID system, Cartridge & Infusion set Change every __ days (Required) <input type="checkbox"/> 3 (qty 30) <input type="checkbox"/> 2.25 (qty 40) <input type="checkbox"/> 2 (qty 50) <input type="checkbox"/> 1 (qty 90)			
Applicable refills for any of the AID systems: <input type="checkbox"/> 3 months <input type="checkbox"/> 6 months <input type="checkbox"/> 12 months			

3	QUALIFICATIONS AND INDICATIONS AS PER MEDICAL RECORDS (CHECK ALL THAT APPLY):		
<input type="checkbox"/> Patient/caregiver has the ability to operate and can use an insulin pump to manage blood glucose			
<input type="checkbox"/> Patient treated with insulin and or have documented level 2 or level 3 hypoglycemic events.			
<input type="checkbox"/> Multiple Daily Injections 3-4 times per day with self-adjustments to insulin doses.			
<input type="checkbox"/> Current Insulin Pump is out of warranty, or its functionality no longer meets the patient's medical need.			
<input type="checkbox"/> Patient is pregnant or planning pregnancy.			
NOTES:			

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

Prescribing Provider / Primary Care Physician (VITAL) 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.

PRESCRIBING PROVIDER SIGNATURE (SIGNATURE STAMPS ARE NOT ACCEPTABLE)	Date:
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5	PRIMARY CARE PHYSICIAN - VITAL		
PRIMARY CARE PHYSICIAN - VITAL SIGNATURE (SIGNATURE STAMPS ARE NOT ACCEPTABLE)		PR Lic #:	Date: