STATEMENT OF MEDICAL NECESSITY AND PRESCRIPTION ORDER

**** Confidential Patient Health Information ****

This form serves as a prescription and Statement of Medical Necessity for the Tandem insulin pump or Dexcom CGM and all related diabetes supplies to be provided by Nazareno Services LLC.

1 PATIENT ORDER INFORMATION (Check Items Being Prescribed)

Name:	DOB:	☐ DMT1 ☐ DMT2	Last date visit:
Address:	City:	Zip:	Phone:
Currently on insulin pump? ☐ Yes ☐ No / Currently on CGM Therapy? ☐ Yes ☐ No	Insurance:	ID or Contract #	Effective Date:

☐ TANDEM t:slim X2™ Insulin Pump with Control-IQ™ (Prescribed only by Endocrinologists)

- CARTRIDGE & INFUSION SET CHANGE FREQUENCY ☐ Every 3 day (Qty.30) ☐ Every 2 day (Qty.50)

☐ Patient/Caregiver has completed diabetes education (including carbohydrate counting) and is motivated to maintain optimal glucose control.

☐ Patient/Caregiver has the ability to operate and can use an insulin pump to manage blood glucose.

WARNING: Control-IQ technology should not be used by anyone under the age of six 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.

☐ DEXCOM G6 Continuous Glucose Monitoring (iCGM)

Sensors – Sig: Dispense 1-3 boxes. ● Transmitter – Dispense 2 / 1 Refill. ● Receiver – Dispense 1 / 0 Refills
Direction for use: Site change per manufacture recommendation, up to 90 days unless otherwise noted.

☐ Patient demonstrate an understanding of technology and are motivated to use the device correctly and consistently, are expected to adhere to comprehensive diabetes treatment plan and can use the device to recognize alerts and alarms.

2 SUPPORTING CLINICAL INDICATIONS (Current therapy is failing due to)

a) # SMBG per day:	b) ICD-10 Diagnosis Code: ☐ E10.65 ☐ E10.9 ☐ E11.9 ☐ E11.65 Other:
c) # Multiple daily injections per day:	d) Insulin regiment: ☐ Humalog® ☐ Novolog® ☐ Lantus® Other:

☐ Recurring episodes severe hyperglycemia	☐ Hypoglycemia unawareness	☐ History of nocturnal hypoglycemia
☐ History of severe glycemic excursions	☐ Dawn phenomenon	☐ Patient is pregnant or planning pregnancy

☐ Require frequent adjustments of the insulin treatment regimen, based on therapeutic BGM or CGM test results.

☐ Patient has been hospitalized or has requires paramedical treatment for low blood sugar.

☐ Evidence of unexplained severe hypoglycemia episodes requiring external assistance for recovery.

☐ Patient performs multiple daily injections consisting of 3-4 or more injections per day and is able to self-adjust insulin doses

☐ Variations in the day-to-day schedule and/or exercise prevent the achievement of successful glycemic control with MDI.

☐ Current Insulin Pump or CGM is out of warranty or its functionality no longer meets the patient's medical need

☐ Continue current pump settings

Comments:

3 PRESCRIBER PHYSICIAN INFORMATION

Physician:			Email Address:	
Address:			Phone:	Fax:
City:	State: PR	Zip:	NPI#	PR Lic #:
Prescribing Provider Signature: X				DATE :

4 PRIMARY CARE PHYSICIAN - VITAL

Name & signature: X	PR Lic #	NPI#

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

*Please send completed by email : **rx@nazarenollc.com** or Fax: 787-288-0704. Contact us at 787-740-2934*