nazareno DIABETES

STATEMENT OF MEDICAL NECESSITY AND PRESCRIPTION ORDER

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

Dexcom

TANDEM DIABETES CARE

This document serves as 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 NEW - PATIENT ORDER INFORMATION

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:

DIAGNOSIS CODE: ICD-10 Code ☐ E10.65 ☐ E10.9 ☐ E11.9 ☐ E11.65 ☐ 024.41 (for G7 olnly) Other:

# Fingerstick per day:	# Injections per day:	Weight _____ (lbs.)	HbA1c – Result:

Insulin regiment: ☐ Rapid-Acting _____ totals units per day ☐ Long-Acting _____ total units per day

2 PRESCRIPTION INFORMATION

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

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

1. ☐ Patient/Caregiver has completed diabetes education (including carbohydrate counting) and is motivated to maintain optimal glucose control.
2. ☐ Patient/Caregiver has the ability to operate and can use an insulin pump to manage blood glucose.

b. ☐ DEXCOM G6

Sensors – Sig: Dispense 1-3 boxes. ● Transmitter – Dispense 2 ● Receiver – Dispense 1

c. ☐ DEXCOM G7

1 one-pack 10-day sensor with integrated Transmitter ● 1 Receiver – Dispense 1 QUANTITY _____ REFILLS _____

Quantity 1 = 10 day supply; Quantity 3 = 30-day supply; Quantity 9 = 90-day supply

3 CLINICAL CONSIDERATIONS

☐ Recurring episodes severe hyperglycemia	
☐ History of severe glycemic excursions	
☐ Require frequent adjustments of the insulin treatment regimen, based on therapeutic BGM or CGM test results.	
☐ History of hypoglycemia unawareness, severed hypoglycemia resulting in third party intervention and/or hospitalization / paramedical treatment	
☐ 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 is out of warranty, or its functionality no longer meets the patient's medical need.	Out of warranty date:
☐ History of ER/hospital visits: diabetic ketoacidosis (DKA), severe hypoglycemia	
Comments:	

4 PRESCRIBER PHYSICIAN INFORMATION

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

5 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.

Email to: rx@nazarenollc.com