nazareno DIABETES

PRESCRIPTION ORDER

** Confidential Patient Health Information **

1 PATIENT ORDER

Name:	DOB: (M / D / Year) 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 dexcom PRESCRIPTION INFORMATION FreeStyle Libre

☐ **Dexcom G6**
Receiver / sensor / transmitter / Dispense 90 days' supply

☐ **Dexcom G7**
Receiver / sensor / transmitter / Dispense 90 days' supply

☐ **FreeStyle Libre 2 Plus sensor**
Receiver / sensor / transmitter / Dispense 90 days' supply

☐ **FreeStyle Libre 3 Plus sensor** *
Receiver / sensor / transmitter / Dispense 90 days' supply.
* Currently not compatible with any Tandem Aid System

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

TANDEM Diabetes Care — TANDEM Insulin Pump with Control-IQ™ Technology & Supplies

☐ **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

Applicable refills: ☐ 3 months ☐ 6 months ☐ 12 months

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.
Use any CGM sensor and reader per manufacturer guidelines, in accordance with FDA indications for use.

PRESCRIBING PROVIDER SIGNATURE (SIGNATURE STAMPS ARE NOT ACCEPTABLE)	DATE

Email completed form to: rx@nazarenollc.com

This order is subject to Health Plan Approval