nazareno DIABETES CARE

PRESCRIPTION ORDER

Confidential Patient Health Information

1 PATIENT ORDER INFORMATION

Patient Name:	DOB: (mm/dd/yyyy) Phone #:	☐ New ☐ Supplies Refill

***Patient recent weight (lbs.)** _____ ***Total Daily Insulin (TDI)** _____ **A1C:** _____

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

2 PRESCRIPTION INFORMATION

dexcom FreeStyle

Dexcom

☐ **G6**

☐ **G7**

FreeStyle Libre

☐ **2 Plus** * Not compatible with iLet Aid System

☐ **3 Plus** * Not compatible with any Tandem Aid System

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

TANDEM DIABETES CARE

☐ **t: slim X2™** ☐ **Tandem Mobi**

Infusion Set Type:

☐ AutoSoft XC ☐ AutoSoft 30 ☐ AutoSoft 90 ☐ TruSteel ☐ VariSoft

* **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. ☐ Prescriber to provide pump settings on PSO. Box must be checked if using non-U-100 analog insulin in pump.

Beta Bionics

☐ **iLet**

Infusion Set Type:

☐ Contact Detach: Steel Cannula

☐ Inset: Soft Cannula 6mm

AID system, Cartridge & Infusion set Change every __ days (Required) ☐ 3 (qty 30) ☐ 2.25 (qty 40) ☐ 2 (qty 50) ☐ 1 (qty 90)

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

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

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

☐ 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.

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:

5 PRIMARY CARE PHYSICIAN - VITAL

PRIMARY CARE PHYSICIAN – VITAL SIGNATURE (SIGNATURE STAMPS ARE NOT ACCEPTABLE)	PR Lic #:	Date:

Email completed form to: rx@nazarenollc.com

This order is subject to Health Plan Approval