DEXCOM CGM / PUMP INSULIN SUPPLY
PHYSICIAN ORDER / PRESCRIPTION

INSTRUCTIONS: PLEASE COMPLETE ALL SECTIONS INDICATED BY THE **FIVE** NUMBERED CIRCLES
CORRECTIONS ON THIS FORM ARE NOT ACCEPTABLE, **IF AN ERROR OCCURS; PLEASE CALL FOR A NEW FORM.**
LENGTH OF NEED: DME = LIFETIME (i.e. 99 months)/ Pharmacy = 4 refills unless otherwise specified here_____.

PATIENT INFORMATION: ORDER DATE**:**

NAME:	DOB:	PHONE:
ADDRESS:		

1 PATIENT'S DIAGNOSIS CODE SPECIFIC TO DIABETIC COMPLICATIONS? ICD-10 (CHECK BOX BELOW)

☐ **E10.9** ☐ **E10.65** ☐ **E11.65** ☐ **E11.9** **OTHER DX** _____

2 IS PATIENT ON-INSULIN? ☐NO ☐YES ***IF* YES, IS PATIENT ON AN INSULIN PUMP? (**ANSWER BELOW**)**

***NO*, PROVIDE # OF INSULIN INJECTIONS PER DAY HERE➔:** ☐

YES, COMPLETE SECTION #3 TO PRESCRIBE INSULIN ↙:

ITEMS TO BE DISPENSED – USE PER MANUFACTURER RECOMMENDATION

CGM: BRAND AND MODEL PER PATIENT PREFERENCE. (Refills timing based on Insurance coverage.)

DEXCOM G6 or G7 SENSOR	Change Every 10 Days	Dispense: Ten / 100 days	4 refills per year
DEXCOM G6 TRANSMITTER	Change Every 90 Days	Dispense: Two / 180 days	2 refills per year
DEXCOM G6 or G7 RECEIVER	Use Per Manufacturer Instructions	Dispense: One / 365 days	1 refills per year

INSULIN VIALS 100 units/mL : USE AS DIRECTED PER PRESCRIBER IN INSULIN PUMP

3 ☐ **INSULIN LISPRO** same insulin in HUMALOG
DISPENSE: Twelve 10mL vials **or Alt:** ____10mL vials**/90 Days**, **4** refills per year

PEN NEEDLES and **SYRINGES: Inject insulin _____ times per day.**
DISPENSE: 100 Day Supply Based on Injection Frequency, **4** refills per year

INSULIN COVERED BY MEDICARE PART B FOR PUMP PATIENTS ONLY

This document serves as a Prescription and/or Statement of Medical Necessity for the above referenced patient. I confirm that I have seen this patient within the last six (6) months to evaluate their diabetes control and **in addition to the above, I prescribe the following supplies in the following quantities based on injection and change frequencies written above:** INSULIN– Vials J1817 or INSULIN ITEMs with NDCs for those who qualify under State/Medicare/Payor Guidelines. CGM System, to include K0554 / E2103 / A9278 / A4238 Reader / Receiver and SENSORs / SUPPLY ALLOWANCE – K0553 / A4239 / A9276 for related supplies (glucometer, test strips, lancets, lancing device and control solution, when covered by insurance) and up to a 100-day supply of Pen Needles, Syringes, Sterile Wipes based on injection and change frequencies written above along with other associated diabetes supplies will be provided.

By my signature below, I confirm that all the information contained on this Physician Order form accurately reflects the patient's diabetic condition, and the treatment regimen which I am prescribing. This patient's medical records substantiate the items prescribed. I will maintain this signed original document in the patient's medical record for post-payment purposes. I agree to follow up on the patient every six (6) months while under my care for control of diabetes. I communicated to the patient/ caregiver the recommended treatment plan, including potential risks, benefits, precautions and limitations of the products, including off-label usage, which I authorize. The patient/caregiver is physically and intellectually able to follow instructions for controlling diabetes and to operate the items prescribed, and has been or is being trained in their use. DAW = 0, no product selection indicated, unless prescriber indicates otherwise _____. For Virginia patients, RPh is authorized to make copies of this order to circle one prescribed item per copy to meet the pharmacy law requirement of single item prescription. Nothing will be changed from this original order.

4 SIGNATURE: **5 DATE:**

PRESCRIBER INFORMATION:

NAME:	NPI #:	PHONE#:
EMAIL ADDRESS:	DEA#:	FAX#:
OFFICE STREET ADDRESS:		
OFFICE CONTACT/ NOTES:		

THE ABOVE ITEMS MAY BE ELECTRONICALLY PRESCRIBED VIA PARACHUTE