MEDICARE PART B INSULIN SUPPLY
PHYSICIAN ORDER / PRESCRIPTION

INSTRUCTIONS: PLEASE COMPLETE ALL SECTIONS INDICATED BY THE **FOUR** 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? (**CHECK BOX BELOW**)**

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

ITEMS TO BE DISPENSED (COMPLETE DETAILS BELOW)

2 **INSULIN VIALS 100 units/mL:** USE AS DIRECTED PER PRESCRIBER IN INSULIN PUMP.
INSULIN LISPRO (HUMALOG) **DISPENSE:** Twelve 10mL vials **or Alt:** ____10mL vials**/90 Days** **4** refills per year

PEN NEEDLES and **SYRINGES: Inject insulin _____ times per day. (To Be Used in Case of Pump Failure)**
DISPENSE: 100 Day Supply Based on Injection Frequency **4** refills per year

STERILE WIPES: QTY BASED ON CHANGE AND INJECTION FREQUENCIES ABOVE 100 DAY SUPPLY **4** refills per year

INSULIN COVERED BY MEDICARE PART B FOR PUMP PTS ONLY.

This document serves as a Prescription and 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 **I prescribe the following supplies in the following quantities based on pump change and injection frequencies written above**— (Please line through any that do not apply) INSULIN LISPRO – Insulin Vials for Insulin Pump - J1817, and up to a 100 day supply (15 Refills) of Sterile Wipes, Tegaderm, Skin Prep, Skin Tac, Tac Away, IV Prep, IV 300 Dressing, and 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.

3 **SIGNATURE:** **4** **DATE:**

PRESCRIBING PROVIDER—		
NAME:	PHONE#:	FAX#:
NPI #:	DEA#:	EMAIL ADDRESS:
OFFICE STREET ADDRESS:		
OFFICE CONTACT:		
PRACTICE NAME:		
OTHER NOTES:		

THE ABOVE ITEMS MAY BE ELECTRONICALLY PRESCRIBED VIA PARACHUTE