MEDICARE MEDTRONIC EIS PUMP SUPPLY AND INSULIN
PHYSICIAN ORDER / PRESCRIPTION

INSTRUCTIONS: PLEASE COMPLETE ALL SECTIONS INDICATED BY THE **SIX** 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 ITEMS TO BE DISPENSED – USE PER MANUFACTURER RECOMMENDATION

☐ **MEDTRONIC INSULIN PUMP 780G** every 5 years.
PUMP SUPPLIES:
EXTENDED INSULIN INFUSION SET: SIZING PER PATIENT PREFERENCE
CHANGE FREQUENCY: ☐ Every 7 days (Qty 13) or ☐ Every 6 days (Qty 15) **4** refills per year
EXTENDED RESERVOIR BASED ON TOTAL DAILY DOSE (TDD) _____units
Quantity to be calculated by pharmacist:

3 CGM: MODEL PER PATIENT PREFERENCE AND INSURANCE COVERAGE
☐ **GUARDIAN SENSOR 3 (630G pump)** CHANGE EVERY 7 DAYS (Qty 15) & **LINK 3 TRANSMITTER** Annually
☐ **GUARDIAN SENSOR 3 (770G & 780G pumps)** CHANGE EVERY 7 DAYS (Qty 15) & **LINK 3 TRANSMITTER** Annually
☐ **GUARDIAN SENSOR 4 (780G pump)** CHANGE EVERY 7 DAYS (Qty 15) & **LINK 4 TRANSMITTER** Annually

4 INSULIN VIALS 100 units/mL: USE AS DIRECTED PER PRESCRIBER IN INSULIN PUMP (for Medicare Part B pumps)
☐ **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.** **4** refills per year
DISPENSE: 100 Day Supply Based on Injection Frequency
STERILE WIPES: QTY BASED ON CHANGE AND INJECTION FREQUENCIES ABOVE, 100-DAY SUPPLY **4** refills per year

This document serves as a Prescription and/or Statement of Medical Necessity for the above referenced patient. I prescribe the following supplies in quantities based on 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.

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.

5 SIGNATURE: **6 DATE:**

PRESCRIBER INFORMATION: PLEASE COMPLETE ANY DETAILS NOT ON FILE TO FACILITATE PROCESSING.

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

THE ABOVE ITEMS MAY BE ELECTRONICALLY PRESCRIBED VIA PARACHUTE