OMNIPOD / INSULIN SUPPLY
PHYSICIAN ORDER / PRESCRIPTION

INSTRUCTIONS: PLEASE COMPLETE ALL SECTIONS INDICATED BY THE **FIVE** ARROWS AS NEEDED
CORRECTIONS ON THIS FORM ARE NOT ACCEPTABLE, **IF AN ERROR OCCURS; PLEASE CALL FOR A NEW FORM.**

Duration of Need is **LIFETIME** unless otherwise specified _____.

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** _____

OMNIPOD or OMNIPOD DASH or OMNIPOD 5 (PER PATIENT PREFERENCE OR PRESCRIBER TO INDICATE PREFERENCE)

Dispense one E0784 / E0607: OmniPod Personal Diabetes Manager (PDM) or Intro Kit as needed.
Dispense A9274: External Ambulatory Insulin Delivery Pods based on change/replace frequency below.

2 CHANGE / REPLACE INSULIN POD EVERY: (MUST CHECK ONE ☑)

☐ **24 hours** = DISPENSE 90 Pods / 90 Days
☐ **36 hours** = DISPENSE 60 Pods / 90 Days
☐ **48 hours*** = DISPENSE 10 Pods / 20 Days or
DISPENSE 15 Pods / 30 Days or
DISPENSE 40 Pods / 80 Days or
DISPENSE 45 Pods / 90 Days or 50 Pods / 90 Days
☐ **72 hours** = DISPENSE 30 Pods required for a 90-day supply

Pod Refills: 4 90-Day refills per year
May dispense as monthly refills.
***Max Day Supply determined by Insurance and Quantities Per Box**

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient and items. I confirm that I have seen this patient within the last six (6) months to evaluate their diabetes control.

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. This prescription may be transferred to another pharmacy per patient preference. 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. For DAW: Not Applicable. 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:**

PRESCRIBING PROVIDER—

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

THE ABOVE ITEMS MAY BE ELECTRONICALLY PRESCRIBED VIA PARACHUTE