INPEN
PHYSICIAN ORDER / PRESCRIPTION

1 Patient information

CONTACT		INSURANCE		
NAME (FIRST, MIDDLE, LAST)		INSURANCE NAME	PLAN PHONE	PATIENT ID
ADDRESS		RX BIN (REQUIRED)	RX PCN	RX GROUP
DOB (MM/DD/YY)	PHONE	EMAIL		PATIENT DIAGNOSIS CODE

2 Choose ONE InPen™

HUMALOG
☐ InPen (Humalog®)
Max Qty 2 / 365
Color Options are Patient Preference

OR

NOVOLOG/FIASP
☐ InPen (Novolog®/Fiasp®)
Max Qty 2 / 365
Color Options are Patient Preference

Note: Insulin must be dispensed at local Pharmacy with separate prescription:
Humalog® U100 Cartridges (NDC 00002751659),
NovoLog® U100 Cartridges (NDC 00169330312),
Fiasp® U100 Cartridges (NDC 00169320515)

PEN NEEDLES
☐ Max # Injections Per Day _____
100 Day's Supply/ 4 Refills

3 Specify patient Therapy Settings (Required before first use of InPen) – Section 5 of User Guide

☐ I confirm patient has been provided a copy of the therapy settings.

A Insulin Settings

Maximum Calculated Dose _____ U

Duration of Insulin Action _____ hh:mm

TIME OF DAY – OFF

Time of Day — OFF

Target Blood Glucose _____ mg/dL

Insulin Sensitivity Factor _____ mg/dL/U

OR

TIME OF DAY – ON

Time of Day __:__ __:__ __:__ __:__ AM / PM

Target Blood Glucose ____ ____ ____ ____ mg/dL

Insulin Sensitivity Factor ____ ____ ____ ____ mg/dL/U

B Select ONE Meal Therapy Mode

☐ **Carb Counting**

Insulin to Carb Ratio _____ g/U

OR

*Time of Day __:__ __:__ __:__ __:__ AM / PM

Insulin to Carb Ratio ____ ____ ____ ____ g/U

*** Time settings should match exact times in section A**

☐ **Meal Estimation**

	Low Carb	Medium Carb	High Carb
Breakfast	___ U	___ U	___ U
Lunch	___ U	___ U	___ U
Dinner	___ U	___ U	___ U
Snack	___ U	___ U	___ U

☐ **Fixed Dose**

Breakfast	___ U
Lunch	___ U
Dinner	___ U
Snack	___ U

C Long-Acting

Insulin Type _____

Doses per day _____

DOSE 1

Usual Amount _____ U

Time __:__ hh:mm

DOSE 2

Usual Amount _____ U

Time __:__ hh:mm

4 Complete, sign and fax this form to Companion Medical or retail pharmacy.

I certify that I am the prescribing provider and have reviewed all of the order information above and have reviewed the prescribing notes on the back of these orders.

DATE (MONTH/DAY/YEAR	HEALTH CARE PROVIDER SIGNATURE *	HEALTH CARE PROVIDER PRINT NAME *	
FACILITY	ADDRESS	CITY	STATE
NPI#	PHONE / FAX	EMAIL	