BETA BIONICS / DEXCOM
PHYSICIAN ORDER / PRESCRIPTION

PATIENT ORDER INFORMATION (CHECK ITEM(S) BEING PRESCRIBED)

PATIENT NAME	DATE OF BIRTH	PARENT/GUARDIAN (FIRST, LAST)

PATIENT ADDRESS	PHONE NUMBER

ITEM BEING PRESCRIBED:	ORDER START DATE:	LENGTH OF NEED:
☐ **iLet insulin pump**		**ILET INSULIN PUMP, PUMP & CGM SUPPLIES:** ☐ Lifetime (i.e., 99 yrs.) or other☐_____

INFUSION SET TYPE:

☐ **iLet Cartridge Kit 10-pack 1.6 mL + Connect Adapter 10-pack**

INFUSION SET TYPE:	CARTRIDGE AND INFUSION SET CHANGE FREQUENCY:
☐ Contact Detach: 6mm Steel needle, 23" tube length	☐ Every 3 days (Qty. 30 + 3 refills)
☐ Inset: 6mm Teflon cannula, 23" tube length	☐ Every 2 days (Qty. 50 + 3 refills)
☐ Patient Preference	☐ Every 1 day (Qty. 90 + 3 refills)

CGM: BRAND AND MODEL PER PATIENT PREFERENCE. (Refills 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

CURRENT THERAPY – COMPLETE SECTIONS BELOW

ICD-10 DIAGNOSIS CODE

☐ Type 1 diabetes without complications (E10.9)
☐ Type 1 diabetes with complications (E10.65)
☐ Other: _____

MOST RECENT HbA1c

Result Date:

Multiple Daily Injections Details

☐ Patient performs multiple daily injections consisting of 3-4 or more injections per day and is able to self-adjust insulin doses.
☐ Variations in the day-to-day schedule and/or exercise prevent the achievement of successful glycemic control with multiple daily injections.
☐ Despite frequent therapy adjustments, the patient experiences suboptimal glycemic control-evidenced by wide glycemic fluctuations ranging from _____ to _____ mg/dl.

Insulin Pump Details

☐ Current pump functionality no longer meets the patient's medical needs and/or is out of warranty.
☐ Mechanical or medical reasons for replacement:
_____

Out of warranty date: _____ or
☐ not available / not applicable

PRESCRIBER INFORMATION

PRESCRIBING PROVIDER NAME	NPI#	DEA#	PHONE NUMBER

OFFICE STREET ADDRESS	FAX NUMBER

EMAIL ADDRESS

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 line with the above, I prescribe the following supplies in quantities based on 90-day supply:** CGM System, to include K0554 / E2103 / A9278 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 pump and pump supplies A4224 / A4225 or A4230 / A4232.

Prescribing Provider Attestation and Signature/Date

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 Physician Order is being sent to Advanced Diabetes Supply (ADS) per the patient's choice. I understand I am sending the prescribed items to ADS, a pharmacy and medical device supplier, to be filled per patient's 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. 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.

PRESCRIBER SIGNATURE: (SIGNATURE STAMPS ARE NOT ACCEPTABLE)	DATE (MM/DD/YYYY)
X	

YOU MAY ELECTRONICALLY PRESCRIBE THE ABOVE ITEMS VIA PARACHUTE **TO: "ADVANCED DIABETES SUPPLY" OR**
FAX DOCUMENTS BACK TO **(760)517-8999 QUESTIONS** Email BetaBionics@northcoastmed.com