bedard
Pharmacy & Medical Supplies ☑
Phone: 207-784-3700 | Fax: 207-795-7622

Diabetic Testing Supplies Detailed Written Order

1. Patient Information

Patient Name:_____ DOB:_____ Phone #:_____

Is patient currently in a facility? ☐ Y ☐ N If yes, Facility Name:_____ Facility Phone #:_____

☐ Patient Face Sheet/Demographics & Chart Notes Included

2. Provider Information

Provider Name:_____ NPI #:_____ Phone #:_____

Fax #:_____ Date of most recent face-to-face exam:_____

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for diabetic testing supplies. I certify that I am the provider identified above and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Provider Signature:_____ Date:_____

3. Diagnosis Information

ICD-10 Code: ☐ E10.9 Type 1 Diabetes Mellitus without Complications ☐ E10.65 Type 1 Diabetes Mellitus with Hyperglycemia

☐ E11.9 Type 2 Diabetes Mellitus without Complications ☐ E11.65 Type 2 Diabetes Mellitus with Hyperglycemia

☐ Other:_____

4. Supporting Criteria

1. Do you treat this patient for diabetes? ☐ Y ☐ N
2. Does this patient use injected insulin for diabetes control? ☐ Y ☐ N
3. Are you maintaining medical records reflecting the care provided, but not limited to, evidence that the prescribed frequency of testing is reasonable and necessary? ☐ Y ☐ N
4. Has the patient (or patient's caregiver) successfully completed training or is scheduled to begin training in the use of the monitor, test strips, and lancing devices? ☐ Y ☐ N
5. Is the patient (or patient's caregiver) capable of using the test results to assure the patient's appropriate glycemic control? ☐ Y ☐ N
6. Is the device designed for home use? ☐ Y ☐ N
7. What is the frequency of glucose testing per day?

   Non-Insulin Dependent Patient: ☐ 1 time daily ☐ 1-2 times daily ☐ 2 times daily ☐ Other:_____

   Insulin Dependent Patient: ☐ 1 time daily ☐ 1-2 times daily ☐ 2 times daily ☐ 2-3 times daily ☐ 3 times daily ☐ 3-4 times daily ☐ 4 times daily ☐ Other:_____

8. If this is a refill order, approximately how many test strips/lancets remain?_____

5. Physician's Order / Prescription

Item	Brand & Model (If Medicare, Embrace brand only)	Dispense Qty	Refill Qty	Directions for Use (Sig)
Glucose Monitor (E0607)				☐ Use as directed to test glucose. ☐ Other:
Test Strips (A4253)				☐ Use to test glucose_____ per day. ☐ Other:
Lancets (A4259)				☐ Use to collect blood sample. ☐ Other:
Control Solution (A4256)				☐ Use to test the accuracy of the meter up to once weekly ☐ Other:
Lancing Device (A4258)				☐ Use per package instruction to collect blood sample ☐ Other:
Alcohol Prep Wipes				☐ Use to clean the skin before using lancet. ☐ Other:
Other:				

Patients who **are not currently being treated with insulin** injections, up to **100 test strips** and up to **100 lancets** or one lens shield cartridge is covered every **3 months**.
Patients who **are currently being treated with insulin** injections, up to **100 test strips** and up to **100 lancets** or one lens shield cartridge is covered **every month**.

If refills of quantities of supplies exceed utilization guidelines, documentation that the patient is actually testing at a frequency that corroborates the quantity of supplies that have been dispensed must be present in the physician's and supplier's records.