TANDEM INSULIN PUMP AND SUPPLIES

PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY

PATIENT INFORMATION

Patient Name: ______________________ Date of Birth: ______________

Patient Address: ______________________

Patient Email: ______________________ Phone: ______________

ORDER INFORMATION

Order Type: ☐ New Pump ☐ Replacement Pump *(Current Pump Model:______________)*

*Reason for Replacement:*______________________

Insulin Pump with Control-IQ Technology (E0784)
☐ t:slim X2
☐ Tandem Mobi System
☐ Other:______________

CGM Components
☐ Receiver (A9278/E2103) (1/365)
Sig: Used to check blood glucose daily
☐ Sensors (A4238/A9276/A4239) (365/365 (1 unit = 1 day))
Sig: Change sensors every 10 days
☐ Transmitter (A4238/A9277/A4239) (4/365)
Sig: For use with sensors to check blood glucose daily

CGM Brand & Model
☐ Dexcom G7
☐ Dexcom G7 15 day
☐ Freestyle Libre 2 Plus

Pump Supplies
☐ IV Preps & Adhesives, Transparent Dressings

Testing Supplies
☐ Glucose Meter, Test Strips, Lancets, Control Solution

Infusion Set Type
☐ Patient Preference ☐ Other/Specific Product:______________

Cartridge & Infusion Set Change Frequency
☐ 3 days (qty 30) ☐ 2.25 days (qty 40) ☐ 2 days (qty 50) ☐ 1 day (qty 90)

Length of Need
☐ Lifetime (99 years)
☐ Other: ______________

Date of Diagnosis (MM/DD/YYYY)
____

Diagnosis Code(s):
☐ E10.9 ☐ E10.65 ☐ E10.649 ☐ E11.9 ☐ E11.65 ☐ E11.649 ☐ Other:______________

Reason for Supply Change Frequency and/or Both Steel and Teflon Cannula Sets (check all that apply)
☐ Scar Tissue ☐ Site Sensitivity ☐ Body Type & Site Variation Needs ☐ Insulin Resistance ☐ Other Reason:______________

Current Therapy (check all that apply):
☐ Multiple Daily Injections 3-4 times per day with self-adjustments to insulin doses.
(Pump start orders required for insulin start; saline training okay if clinic protocol.)
☐ Durable Insulin Pump with tubing/infusion sets. Device no longer meets medical needs.
- ☐ Provide new settings on pump start order (advised is using AID). If not checked, current settings will be transferred at training.

☐ Disposable Insulin Delivery Device with patch/pod. Device no longer meets medical needs.
- ☐ Provide new settings on pump start order (advised is using AID). If not checked, current settings will be transferred at training.

Qualifications and Indications as per Medical Records (check all that apply):
☐ Patient/caregiver completed a comprehensive diabetes program & is educated in diabetes management
☐ Patient is routine with appointments
☐ Blood glucose is checked as required or CGM used appropriately
☐ Patient is pregnant or planning pregnancy

Medical Necessity/Reason for Therapy Replacement Need:

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for an Insulin Pump and related supplies.
I certify that I am the physician identified in the above section 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.

PHYSICIAN INFORMATION

Physician name: ______________________ NPI: ______________

Hospital/Clinic: ______________________ Phone: ______________

Address: ______________________ Fax: ______________

Signature: ______________________ Date: ______________

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