bedard
Pharmacy & Medical Supplies

Phone: 207-784-3700 | Fax: 207-795-7622

OMNIPOD PERSONAL DIABETES MANAGER & SUPPLIES PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY

PATIENT INFORMATION			
Name:	DOB:	Gender: ☐ Male ☐ Female	Phone:
Street/City/State/Zip:			

PRESCRIPTION

Order Type *Choose one*

☐ New Pump with Pump Supplies (patient never had before)

☐ Replacement Pump with Pump Supplies

What brand/model did patient use before:_____

PDM System *Choose one*

☐ Omnipod System Personal Diabetes Manager (PDM) (E0784/E0607) Sig: Use as directed to test glucose levels.
Dispense Qty: ☐ 1 Refills: ☐ 0 ☐ Other:_____ Additional Notes:

☐ Omnipod DASH System Personal Diabetes Manager (PDM) (E0784/E0607) Sig: Use as directed to test glucose levels.
Dispense Qty: ☐ 1 Refills: ☐ 0 ☐ Other:_____ Additional Notes:

PDM Supplies *Choose one*

☐ Omnipod Pods (A9274/K0552/A4222)
Dispense Qty: ☐ 45 (48 hr wear/90 days) ☐ 30 (72 hr wear/90 days) ☐ Other:_____ Refills: ☐ 4 ☐ Other:_____
Sig: Replace pod every ☐ 48 hrs (2 days) ☐ 72 hrs (3 days) ☐ Other:_____ Notes:

☐ Omnipod DASH Pods (A9274/K0552/A4222)
Dispense Qty: ☐ 45 (48 hr wear/90 days) ☐ 30 (72 hr wear/90 days) ☐ Other:_____ Refills: ☐ 4 ☐ Other:_____
Sig: Replace pod every ☐ 48 hrs (2 days) ☐ 72 hrs (3 days) ☐ Other:_____ Notes:

STATEMENT OF MEDICAL NECESSITY (PHYSICIAN USE ONLY)

Diagnosis (ICD-10): Type 1: ☐ E10.9 ☐ E10.65 **Type 2:** ☐ E11.9 ☐ E11.65 ☐ **Other:**

Duration of Need: ☐ Lifetime ☐ Other: *Lifetime equals 12 months for non-Medicare. If no duration is specified, prescription defaults to lifetime

Current Insulin Regimen: ☐ Insulin Pump ☐ Multiple Daily Injections (How many injections per day:_____)

Prescribed # of glucose tests per day:	Blood glucose value range: to mg/dL	# SMBG/day: to per day
Fasting Hyperglycemia: mg/dL Date:	Latest HbA1c Result:	Date:

SUPPORTING CLINICAL INDICATIONS (PHYSICIAN CHECK ALL THAT APPLY)

☐ Patient/Caregiver has completed diabetes education including carbohydrate counting and is motivated to maintain optimal glucose control

☐ Patient/Caregiver is motivated, as well as physically and intellectually able to operate the insulin pump

☐ Patient's current pump therapy technology is out of warranty or its functionality does not meet the patient's medical needs

☐ Patient has a phobia regarding or aversion to needles

☐ Work and/or exercise regimen (competitive or prescribed) requires pump to withstand prolonged frequent exposure to water

☐ Patient has been on multiple daily injections at least 3 times per day for at least 6 months, and is able to self-adjust insulin doses

☐ Tubing poses an occupational hazard for patient

☐ Due to impaired vision, patient requires adjustable, high-contrast back-lit colored screen display, not available on current pump

☐ Blood glucose logs on file show blood glucose is checked 4 or more times a day for the past 2 months

☐ Dawn Phenomenon	☐ History of Diabetic Ketoacidosis	☐ Nocturnal Hypoglycemia without coma
☐ Gastroparesis	☐ Retinopathy with macular edema	☐ Hypoglycemia unawareness without coma
☐ Nephropathy	☐ Wide fluctuations in blood glucose values _____ to _____ mg/dL	☐ Patient has a CGM and is calibrating 2x per day
☐ Post Renal Transplant	☐ Frequent or severe hypoglycemia without coma	☐ Patient is pregnant or trying to get pregnant
☐ Neuropathy	☐ Other conditions:	

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a Personal Diabetes Manager and supplies. I certify that I am the physician identified in the below 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:	NPI #:	
Hospital/Clinic:	Phone #:	Fax #:
Street/City/State/Zip:		

Signature:_____ Date:_____

PLEASE FAX COMPLETED FORM TO BEDARD PHARMACY & MEDICAL SUPPLIES: 207-795-7622