bedard MEDICAL SUPPLIES

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TANDEM INSULIN PUMP AND SUPPLIES PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY

Order Type:	**Pump Model (E0784):**	**CGM Components:**	**Pump Supplies**	**Diabetic Supplies**
☐ New Pump ☐ Replacement Pump ***Current Pump Model:***_____ ***Reason for Replacement:***_____ _____ _____	☐ t:slim X2 with Basal-IQ Technology ☐ t:slim X2 with Control-IQ Technology ☐ Other:_____	☐ Receiver (A9278/K0554) (1/365) *Used to check blood glucose daily* ☐ Sensors (A9276/K0553) (365/365 (1 unit = 1 day)) *Change sensors every 10 days* ☐ Transmitter (A9277/K0553) (4/365) *For use with sensors to check blood glucose daily*	☐ Infusion Sets, Reservoirs/ Cartridges, IV Preps & Adhesives, Transparent Dressings	☐ Glucose Meter, Test Strips, Lancets, Control Solution

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

STATEMENT OF MEDICAL NECESSITY (PHYSICIAN USE ONLY)	
Diagnosis (ICD-10): Type 1: ☐ E10.9 ☐ E10.65 **Type 2:** ☐ E11.9 ☐ E11.65 ☐ **Additional diagnosis:**	
# of insulin shots/day in the last 6 months:	Blood glucose value range: to mg/dL
Latest HbA1c Result: Date:	Glucose checks/day: to
# Multiple Daily Injections per day:	# SMBG/day: to per day
Member to change infusion sets every three (3) days, or every _____ day(s)	Number of refills: 11

SUPPORTING CLINICAL INDICATIONS (PHYSICIAN TO CHECK ALL THAT APPLY)
☐ Recurrent episodes of severe hypoglycemia with BG's less than 50 mg/dL. Frequency of episodes:
☐ Hemoglobin HbA1C level is 7.0% or 1% over upper range of normal
☐ History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity and/or very low insulin requirements
☐ Wide fluctuations in prepandial BG levels (e.g., levels commonly exceed 100 mg/dL)
☐ Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL
☐ Day-to-day variations in work schedule, mealtimes and/or activity level, which confound the degree of regimentation required to self-manage glycemia with multiple insulin injections
☐ History of suboptimal glycemic control before or during pregnancy
☐ Suboptimal glycemic and metabolic control after renal transplantation
☐ Poor glycemic control evidenced by 72 hour CGMS sensing trial
Has the patient been on a program of multiple daily injections or insulin with frequent self-adjustment of insulin dose for at least 6 months prior to the initiation of the insulin pump? ☐ Yes ☐ No
SUPPORTING CRITERIA (PHYSICIAN TO CHECK ALL THAT APPLY)
☐ Patient has completed comprehensive diabetes education
☐ Patient has demonstrated ability to self-monitor blood glucose levels as recommended by Physician
☐ Patient is motivated to achieve and maintain improved glycemic control
☐ Patient has been hospitalized or required paramedical treatment for low blood sugar
Insulin reaction notes:
Additional notes:

PHYSICIAN INFORMATION	
Physician:	NPI #:
Hospital/Clinic:	Phone #:
Address:	Fax #:
City/State/Zip:	Office Contact:

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.

Signature:_____ Date:_____

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