

PHYSICIAN'S ORDER CGM & SUPPLIES



Effective Date: ___ / ___ / ___

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OFFICE CONTACT

Name: _____ Phone: _____ Email: _____

PATIENT INFORMATION

PHYSICIAN INFORMATION

PATIENT NAME _____ D.O.B. _____

PHYSICIAN'S NAME _____

ADDRESS _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CITY _____ STATE _____ ZIP _____

PHONE _____ ALT. PHONE _____

PHONE _____ FAX _____

INSURANCE (OR INCLUDE DEMOGRAPHICS)

Primary Insurance Information: _____ ID #: _____

Secondary Insurance Information: _____ ID #: _____

CGM SUPPLIES

Continuous Glucose Monitor & CGM Monthly Supply Allowance

• Pump: YES NO

BRAND: Dexcom Libre

• Insulin: YES NO Name: _____

****REQUIRED****

Model per pt preference unless otherwise stated: _____

• # OF INJECTIONS: _____

Diagnosis Code(s): _____

• **LAST DIABETES VISIT:** ___ / ___ / ___

• Medication List & A1C

****DIAGNOSIS MUST BE LISTED IN THE MEDICAL RECORDS****

INFUSION PUMP SUPPLIES

Infusion Pump Supplies (cartridge & infusion set)

Variations in the day-to-day schedule and/or exercise prevent the achievement of successful glycemic control with multiple daily injections

Every 3 days (30)

Every 2.25 days (40)

Every 2 days (50)

Every 1 day (90)

Despite frequent therapy adjustments, the patient experiences suboptimal glycemic control -- evidenced by wide glycemic fluctuations ranging from _____ to _____ mg/dL

BRAND/MODEL: Tandem

Length of Need: **LIFETIME** OR _____

Physician please note: No product authorized herein will be supplied without the consent of the patient.

PHYSICIAN SIGNATURE

DATE

NPI #

BY SIGNING ABOVE, I AM STATING THAT I am or was this patient's treating physician during the order period and this is my attestation of medical necessity. The order accurately reflects the patient's condition. I certify that patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this written order. I will maintain an original signed copy of this order in my medical records and make it available to Total Medical Supply, Medicare, their authorized agents or other insurer, if required. By signing above I certify that the patient is being seen every 6 months to ensure adherence to treatment instructions.

PLEASE SEND DEMOGRAPHICS AND OFFICE VISIT NOTES TO 337-443-7364