

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 310-424-4590