Advanced Diabetes Supply

DEXCOM G6 / PUMP INSULIN SUPPLY
PHYSICIAN ORDER / PRESCRIPTION

INSTRUCTIONS: PLEASE COMPLETE ALL SECTIONS INDICATED BY THE **FIVE** ARROWS
CORRECTIONS ON THIS FORM ARE NOT ACCEPTABLE, **IF AN ERROR OCCURS; PLEASE CALL FOR A NEW FORM.**

If not otherwise specified, maximum allowed Duration of Need is 12 months. Duration of Need ____.**15 Refills Maximum.**

PATIENT INFORMATION: **ORDER DATE:**

NAME:	DOB:	PHONE:
ADDRESS:		

1 PATIENT'S DIAGNOSIS CODE SPECIFIC TO DIABETIC COMPLICATIONS? ICD-10 (CHECK BOX BELOW)

☐ **E10.9** ☐ **E10.65** ☐ **E11.65** ☐ **E11.9** **OTHER DX** ______________

2 PATIENT IS ON-INSULIN, IS THE PATIENT ON AN INSULIN PUMP? (PROVIDE ANSWER BELOW)

***NO*, PROVIDE # OF INSULIN INJECTIONS PER DAY HERE➔:** ☐

YES, COMPLETE SECTION #3 TO PRESCRIBE INSULIN LISPRO ⬋:

ITEMS TO BE DISPENSED – USE PER MANUFACTURER RECOMMENDATION

G6 RECEIVER:	**G6 TRANSMITTER:**	**G6 SENSORS:**
Use Per Manufacturer Instructions.	Change every **90 days**.	Change sensor every **10 days**.
Dispense: One Reader / 365 days	**Dispense: Two / 180 days** –	**Dispense: Ten Sensors / 100 days** –
0 refills	**2** refills	**3** refills

INSULIN LISPRO 100 units/mL: Use As Directed Per Prescriber. **COVERED / DISPENSED FOR MEDICARE PUMP PTS ONLY.**

3 DISPENSE: ☐ Nine 10mL vials **or** ☐ Eighteen 10mL vials **or** **Other:** ________ 10mL vials **/ 90 Days** **4** refills

PEN NEEDLES and **SYRINGES: Inject insulin _______ times per day.** (To Be Used In Case of Pump Failure Only.)

DISPENSE: 100 Day Supply Based on Injection Frequency **4** refills

INSULIN COVERED BY MEDICARE PART B FOR PUMP PTS ONLY, CERTAIN STATE RESTRICTIONS MAY APPLY.

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient. I confirm that I have seen this patient within the last six (6) months to evaluate their diabetes control and **I prescribe the following supplies in the following quantities based on frequencies written above—** (Please line through any that do not apply) INSULIN LISPRO – Insulin Vials for Insulin Pump - J1817, Dexcom Continuous Glucose Monitoring System, to include a DEXCOM RECEIVER - A9278 or K0554, DEXCOM TRANSMITTER – A9277 or K0553 and DEXCOM SENSORS and SUPPLY ALLOWANCE (WHERE APPLICABLE) – A9276 or K0553 for related supplies (glucometer, test strips, lancets, lancing device and control solution) and up to a **100 day supply (15 Refills)** of Pen Needles, Syringes and Sterile Wipes based on injection frequency written above along with Ketone Strips, Ketostix, Tegaderm, Skin Prep, Skin Tac, Tac Away, IV Prep, IV 300 Dressing, and other associated diabetes supplies, to be provided by Advanced Diabetes Supply or an authorized distributor.

By my signature below, I confirm that the patient has diabetes and is being treated by me. I confirm that I have communicated to the patient/caregiver the recommended treatment plan, including disclosure of potential risk, benefits, and precautions. I confirm this Physician Order is being sent to Advanced Diabetes Supply per the patient's choice. All the information contained on this Physician Order form accurately reflects the patient's diabetic condition and the treatment regimen that I have prescribed. The medical records for this patient substantiate the items prescribed. The patient/caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items. I will maintain this signed original document in the patient's medical record file for post-payment purposes. I agree to follow up on the patient every six (6) months while under my care for control of diabetes. I confirm the Patient/caregiver is physically and intellectually able to operate the items prescribed, and has been or is being trained in its use. I DEEM THE ABOVE PRESCRIBED PRODUCTS REASONABLE AND NECESSARY. I confirm this Physician Order is being sent to Advanced Diabetes Supply per the patient's choice.

4 SIGNATURE: **5 DATE:**

PRESCRIBING PROVIDER—

NAME:	PHONE#:
NPI #:	FAX#:
DEA#:	EMAIL ADDRESS:
OFFICE STREET ADDRESS:	
PRACTICE NAME AND/OR NOTES:	

FAX DOCUMENTS BACK TO **1-760-444-8771**

QUESTIONS eMAIL **CGM**@NORTHCOASTMED.COM