ADS Advanced Diabetes Supply

DEXCOM G7 / PUMP INSULIN SUPPLY
PHYSICIAN ORDER / PRESCRIPTION

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

Duration of Need is **LIFETIME** unless otherwise specified _____.

PATIENT INFORMATION: ORDER DATE:

NAME:	DOB:	PHONE:
ADDRESS:		

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

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

❷ 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 ↙:

ITEMS TO BE DISPENSED – USE PER MANUFACTURER RECOMMENDATION

DEXCOM G7
or other K0554 / E2103 / A9278 CGM Receiver / Reader
Brand / Model Per Patient Preference
Use Per Manufacturer Instructions.
Dispense: One Reader / 365 days. 1 refill per year.
Based on Insurance Coverage

DEXCOM G7
or other K0553 / A4239 / A9276, A9277 Sensor / CGM Supply
Brand / Model Per Patient Preference
Change sensor every **10 days**.
Dispense: Nine Sensors / 90 Days. 4 refills per year.

INSULIN VIALS 100 units/mL : USE ___ mL PER DAY, OR AS DIRECTED BY PRESCRIBER.

❸ ☐ **INSULIN LISPRO** same insulin in HUMALOG **or** ☐ **INSULIN ASPART** same insulin in NOVOLOG
DISPENSE: ☐ Nine 10mL vials **or** ☐ Eighteen 10mL vials **or Alt:** ____10mL vials/**90 Days** **4** refills per year

PEN NEEDLES and **SYRINGES: Inject insulin _______ times per day.**
DISPENSE: 100 Day Supply Based on Injection Frequency **4** refills per year

This document serves as a Prescription and/or 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 **in addition to the above, I prescribe the following supplies in the following quantities based on frequencies written above:** INSULIN– Vials J1817 or INSULIN ITEMs with NDCs for those who qualify under State/Medicare/Payor Guidelines. CGM System, to include K0554 / E2103 / A9278 Reader / Receiver and SENSORs / SUPPLY ALLOWANCE – K0553 / A4239 / A9276, A9277 for related supplies (glucometer, test strips, lancets, lancing device and control solution, when covered by insurance) and up to a **90 day supply, 4 Refills Per Year of:** Pen Needles, Syringes, Sterile Wipes based on injection frequency written above along with other associated diabetes supplies, to be provided by Advanced Diabetes Supply.

By my signature below, I confirm that all the information contained on this Physician Order form accurately reflects the patient's diabetic condition, and the treatment regimen which I am prescribing. This patient's medical records substantiate the items prescribed. I will maintain this signed original document in the patient's medical record for post-payment purposes. I agree to follow up on the patient every six (6) months while under my care for control of diabetes. This Physician Order is being sent to Advanced Diabetes Supply (ADS) per the patient's choice. I understand I am sending the prescribed items to ADS, a pharmacy and medical device supplier, to be filled per patient's preference. This prescription may be transferred to another pharmacy per patient preference. I communicated to the patient/caregiver the recommended treatment plan, including potential risks, benefits, precautions and limitations of the products, including off-label usage, which I authorize. The patient/caregiver is physically and intellectually able to follow instructions for controlling diabetes and to operate the items prescribed, and has been or is being trained in their use. DAW = 0, no product selection indicated, unless prescriber indicates otherwise _______. Not Applicable. For Virginia patients, RPh is authorized to make copies of this order to circle one prescribed item per copy to meet the pharmacy law requirement of single item prescription. Nothing will be changed from this original order.

❹ SIGNATURE: **❺ DATE:**

PRESCRIBER INFORMATION:

NAME:	NPI #:	PHONE#:
EMAIL ADDRESS:	DEA#:	FAX#:
OFFICE STREET ADDRESS:		
OFFICE CONTACT/ NOTES:		

YOU MAY ELECTRONICALLY PRESCRIBE THE ABOVE ITEMS VIA PARACHUTE **TO: "ADVANCED DIABETES SUPPLY" OR FAX** DOCUMENTS BACK TO **1-760-444-8771 QUESTIONS** eMAIL