



\*\* Confidential Patient Health Information \*\*

This form serves as a prescription and Statement of Medical Necessity for the Tandem insulin pump and all related diabetes supplies to be provided by Tandem Diabetes Care or authorized distributors and/or product development partners.

<b>1</b> <b>PATIENT ORDER INFORMATION</b> (CHECK ITEM BEING PRESCRIBED)	PATIENT NAME (FIRST MIDDLE LAST)		DATE OF BIRTH (MM/DD/YYYY)		GENDER <input type="checkbox"/> Male <input type="checkbox"/> Female			
	PATIENT STREET ADDRESS			ZIP CODE		PHONE NUMBER		
	NEW INSULIN PUMP <input type="checkbox"/> t:slim X2™ insulin pump with access to Basal-IQ® technology <input type="checkbox"/> t:slim X2™ insulin pump with access to Control-IQ™ technology		CARTRIDGE CHANGE FREQUENCY <input type="checkbox"/> Every 3 days (Qty. 30) <input type="checkbox"/> Every 2.25 days (Qty. 40) <input type="checkbox"/> Every 2 days (Qty. 50) <input type="checkbox"/> Every 1 day (Qty. 90)		INFUSION SET CHANGE FREQUENCY <input type="checkbox"/> Every 3 days (Qty. 30) <input type="checkbox"/> Every 2.25 days (Qty. 40) <input type="checkbox"/> Every 2 days (Qty. 50) <input type="checkbox"/> Every 1 day (Qty. 90)		CGM SUPPLIES <input type="checkbox"/> Sensors – 365/365 <input type="checkbox"/> Transmitter – 4/365 <input type="checkbox"/> Receiver – 1/365  <small>Directions for use: Site change per manufacturer recommendation, up to 90 days unless otherwise noted.</small>	
	PRESCRIPTION DURATION <input type="checkbox"/> Pump Warranty		ORDER INITIATION DATE (MM/DD/YYYY)		INFUSION SETS <input type="checkbox"/> Patient Preference <input type="checkbox"/> Other Product, If Applicable: _____		INFUSION SET PREP <input type="checkbox"/> Skin Prep Wipes <input type="checkbox"/> Skin Transparent Dressing	
	DATE OF DIAGNOSIS (MM/YYYY)		ICD-10 DIAGNOSIS CODE		LATEST HbA1c – RESULT %		DATE (MM/DD/YYYY)	
					PRIOR HbA1c – RESULT %		DATE (MM/DD/YYYY)	
<input type="checkbox"/> Patient/Caregiver has completed diabetes education (including carbohydrate counting) and is motivated to maintain optimal glucose control								
<input type="checkbox"/> Patient/Caregiver has the ability to operate and can use an insulin pump to manage blood glucose <input type="checkbox"/> Blood glucose logs indicate blood glucose is checked as required								

<b>CHECK APPLICABLE SECTIONS</b> (SECTION 2 AND/OR 3)	<b>2</b> <input type="checkbox"/> Insulin Pump (Use Current Settings)	<b>3</b> <input type="checkbox"/> Multiple Daily Injections (Pump start orders required for insulin start; saline training ok if clinic protocol)
	<input type="checkbox"/> Current pump is out of warranty and/or its functionality no longer meets the patient's medical need (see "Mechanical or medical reasons for replacement:" for details)	<input type="checkbox"/> Variations in the day-to-day schedule and/or exercise prevent the achievement of successful glycemic control with multiple daily injections
	Mechanical or medical reasons for replacement:	<input type="checkbox"/> Patient performs multiple daily injections consisting of 3-4 or more injections per day and is able to self adjust insulin doses <input type="checkbox"/> Diabetes management reminders required (BG, meal bolus, infusion site change) <input type="checkbox"/> Despite frequent therapy adjustments, the patient experiences suboptimal glycemic control—evidenced by wide glycemic fluctuations ranging from _____ to _____ mg/dL

<b>4</b> <b>OPTIONAL</b> CURRENT THERAPY IS FAILING DUE TO:	<input type="checkbox"/> Patient is pregnant or planning pregnancy	<input type="checkbox"/> Dawn phenomenon (AM hyperglycemia)	<input type="checkbox"/> Hypoglycemia unawareness	<input type="checkbox"/> Nocturnal hypoglycemia
	<input type="checkbox"/> History of ER/hospital visits: diabetic ketoacidosis (DKA), severe hypoglycemia, Other: _____ Date: _____		<input type="checkbox"/> Retinopathy	<input type="checkbox"/> Gastroparesis
	<input type="checkbox"/> Extreme insulin sensitivity	<input type="checkbox"/> Extreme insulin resistance	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Nephropathy
		<input type="checkbox"/> Infusion site disconnect required	<input type="checkbox"/> Hearing acuity requirement	

<b>5</b> <b>PRESCRIBER</b>	PRESCRIBING PROVIDER NAME			NPI		
	OFFICE STREET ADDRESS			PHONE NUMBER		
	CITY		STATE	ZIP CODE		FAX NUMBER
	PRACTICE NAME AND NOTES					

**Prescribing Provider Attestation and Signature/Date**

I certify that I am the prescribing provider identified above and have reviewed all of the order information above. Any statement on my letterhead attached hereto, has been reviewed and signed by me. I certify that all the medical necessity information is true, accurate, and complete, to the best of my knowledge. The patient's record contains supporting documentation, which substantiates the utilization and medical necessity of the products marked above. I understand the indications for use and associated warnings and precautions of the Tandem Diabetes Care® products I have prescribed herein. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

<input checked="" type="checkbox"/> INITIAL TO ACKNOWLEDGE BOXED WARNING	<b>WARNING:</b> Control-IQ technology should not be used by anyone under the age of six years old. It should also not be used in patients who require less than 10 units of insulin per day or who weigh less than 55 pounds.
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<input checked="" type="checkbox"/> PRESCRIBING PROVIDER SIGNATURE (SIGNATURE STAMPS ARE NOT ACCEPTABLE)	DATE (MM/DD/YYYY)	PRESCRIBER EMAIL ADDRESS
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