TANDEM® DIABETES CARE

STATEMENT OF MEDICAL NECESSITY AND PRESCRIPTION ORDER

FAX completed signed form to: **(855) 875-4648**

** 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.

PATIENT ORDER INFORMATION

PATIENT NAME (FIRST MIDDLE LAST)	DATE OF BIRTH (MM/DD/YYYY)	GENDER ☐ Male ☐ Female
PATIENT STREET ADDRESS	ZIP CODE	PHONE NUMBER

INSULIN PUMP (E0784)	CARTRIDGE CHANGE FREQUENCY	INFUSION SET CHANGE FREQUENCY	CGM SUPPLIES
☐ t:slim X2 Insulin Pump (300u)	☐ Every 1 day (Qty. 90)	☐ Every 1 day (Qty. 90)	☐ A9276 Sensors – 365/365 (1 unit = 1 day)
☐ t:slim G4 Insulin Pump (300u)	☐ Every 2 days (Qty. 50)	☐ Every 2 days (Qty. 50)	☐ A9277 Transmitter – 2/365
☐ t:flex Insulin Pump (480u)	☐ Every 2-3 days (Qty. 40)	☐ Every 2-3 days (Qty. 40)	☐ A9278 Receiver – 1/365
	☐ Every 3 days (Qty. 30)	☐ Every 3 days (Qty. 30)	Directions for use: Site change per manufacturer recommendation, up to 90 days unless otherwise noted.

INFUSION SETS
☐ Patient Preference ☐ Other Product, If Applicable: _____

INFUSION SET PREP
☐ Skin Prep Wipes ☐ Skin Transparent Dressing

PRESCRIPTION DURATION (MM/DD/YYYY)
☐ Lifetime ☐ Expire Date: _____

STATEMENT OF MEDICAL NECESSITY FOR INSULIN PUMP USE *(CHECK ALL THAT APPLY)*

CURRENT DIABETES THERAPY: ☐ Insulin Pump (Use Current Settings) ☐ Multiple Daily Injections (Provide Settings)

DATE OF DIAGNOSIS (MM/YYYY)	ICD-10 DIAGNOSIS CODE	LATEST HbA1c – RESULT % DATE (MM/DD/YYYY)	PRIOR HbA1c – RESULT % DATE (MM/DD/YYYY)

☐ Patient/Caregiver has completed diabetes education (including carbohydrate counting) and is motivated to maintain optimal glucose control

☐ Patient/Caregiver has the ability to operate and can use an insulin pump to manage blood glucose

☐ Current pump is out of warranty and its functionality no longer meets the patient's medical need (see "Other Conditions" for details)

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

☐ Blood Glucose logs indicate blood glucose is checked as required

☐ Patient performs multiple daily injections consisting of 3-4 or more injections per day and is able to self-adjust insulin doses

☐ Diabetes management reminders required (BG, meal bolus, infusion site change)

☐ History of ER/hospital visits: Diabetic Ketoacidosis/DKA, severe hypoglycemia,
Other: _____ Date: _____

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

☐ Patient is pregnant or planning pregnancy	☐ Hypoglycemia unawareness	☐ Nephropathy
☐ Dawn phenomenon (AM hyperglycemia)	☐ Nocturnal hypoglycemia	☐ Gastroparesis
☐ Extreme insulin sensitivity	☐ Retinopathy	☐ Hearing acuity requirement
☐ Extreme insulin resistance	☐ Neuropathy	☐ Infusion site disconnect required

☐ Other Conditions:

PRESCRIBER

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 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 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.

PRESCRIBING PROVIDER SIGNATURE (SIGNATURE STAMPS ARE NOT ACCEPTABLE)	DATE (MM/DD/YYYY)
X	

