TANDEM Diabetes Care

STATEMENT OF MEDICAL NECESSITY AND PRESCRIPTION ORDER

Confidential Patient Health Information

Fax completed form to **(619) 810-2304**
Other Fax:_____

This form serves as a prescription & statement of medical necessity for the Tandem insulin pump & related diabetes supplies to be provided by Tandem Diabetes Care or authorized distributors &/or product development partners.

1 PATIENT ORDER INFORMATION

FULL NAME (FIRST MIDDLE LAST)	DATE OF BIRTH (MM/DD/YYYY)	SEX
		☐ Male ☐ Female ☐ Decline to State

STREET ADDRESS	ZIP CODE	PHONE NUMBER

ORDER START DATE (MM/DD/YYYY)	TANDEM INSULIN PUMP WITH CONTROL-IQ TECHNOLOGY	CGM BRAND AND MODEL:
	☐ t:slim X2 ☐ Tandem Mobi system	☐ Dexcom G6 ☐ Dexcom G7 ☐ FreeStyle Libre 2 Plus ☐ Sensors - 365/365 ☐ Transmitter - 4/365 ☐ Receiver - 1/365

CARTRIDGE & INFUSION SET CHANGE EVERY __ DAYS (REQUIRED)	INFUSION SET TYPE
☐ 3 (qty 30) ☐ 2.25 (qty 40) ☐ 2 (qty 50) ☐ 1 (qty 90)	☐ Patient Preference ☐ Other/specific product: _____

2 ORDER START DATE / PUMP & SUPPLIES

LENGTH OF NEED	DIAGNOSIS CODE(S):
☐ Lifetime (99 yrs) ☐ Other:_____	☐ E10.9 ☐ E10.65 ☐ E10.649 ☐ E11.9 ☐ E11.65 ☐ E11.649 ☐ Other _____ DIAGNOSIS DATE (MM/DD/YYYY):

REASON FOR SUPPLY CHANGE FREQUENCY AND/OR BOTH STEEL AND TEFLON CANNULA SETS (CHECK ALL THAT APPLY):

☐ Scar tissue ☐ Site sensitivity ☐ Body type & site variation needs ☐ Insulin resistance ☐ Other reason: _____

CURRENT THERAPY (CHECK ALL THAT APPLY):	QUALIFICATIONS AND INDICATIONS AS PER MEDICAL RECORDS (CHECK ALL THAT APPLY):
☐ Multiple Daily Injections 3-4 times per day with self-adjustments to insulin doses. (Pump start orders required for insulin start; saline training okay if clinic protocol.) ☐ Durable Insulin Pump with tubing/infusion sets. Device no longer meets medical needs. ☐ Provide new settings on pump start order (advised if using AID). If not checked, current settings will be transferred at training. ☐ Disposable Insulin Delivery Device with patch/pod. Device no longer meets medical needs. ☐ Provide new settings on pump start order (advised if using AID). If not checked, current settings will be transferred at training.	☐ Patient/caregiver completed a comprehensive diabetes program & is educated in diabetes management ☐ Patient is routine with appointments ☐ Blood glucose is checked as required or CGM used appropriately ☐ Patient is pregnant or planning pregnancy

MEDICAL NECESSITY/REASON FOR THERAPY REPLACEMENT NEED

3 PRESCRIBER INFORMATION

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.

WARNING: Control-IQ technology should not be used by anyone under the age of 6 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.

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