



** 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.

1 PATIENT ORDER INFORMATION (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		PUMP SUPPLIES <input type="checkbox"/> Infusion Sets and Cartridges		CGM SUPPLIES <input type="checkbox"/> Sensors – 365/365 <input type="checkbox"/> Transmitter – 4/365 <input type="checkbox"/> Receiver – 1/365	
	ORDER INITIATION DATE (MM/DD/YYYY)		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)	<small>Directions for use: Site change per manufacturer recommendation, up to 90 days unless otherwise noted.</small>	
	PRESCRIPTION DURATION <input type="checkbox"/> Lifetime		INFUSION SETS <input type="checkbox"/> Patient Preference <input type="checkbox"/> Other Product, If Applicable: _____			

2 STATEMENT OF MEDICAL NECESSITY FOR INSULIN PUMP USE (CHECK ALL THAT APPLY)	Current Diabetes Therapy: <input type="checkbox"/> Insulin Pump (Use Current Settings) <input type="checkbox"/> Multiple Daily Injections (Pump start orders required for insulin start; saline training ok if clinic protocol)					
	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"/> Current pump is out of warranty and/or its functionality no longer meets the patient's medical need (see "Other conditions" 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					
	<input type="checkbox"/> Blood glucose logs indicate blood glucose is checked as required					
	<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"/> History of ER/hospital visits: diabetic ketoacidosis (DKA), severe hypoglycemia, other: _____ Date: _____					

3 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 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.

INITIAL TO ACKNOWLEDGE BOXED WARNING X	WARNING: 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.		
PRESCRIBING PROVIDER SIGNATURE (SIGNATURE STAMPS ARE NOT ACCEPTABLE) X	DATE (MM/DD/YYYY)	PRESCRIBER EMAIL ADDRESS	