TANDEM Diabetes Care

STATEMENT OF MEDICAL NECESSITY

** Confidential Patient Health Information **

Email or FAX completed form to:
(833) 509-3599
benefitscanada@tandemdiabetes.com

CANADA

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

1 PATIENT ORDER INFORMATION

PATIENT NAME (FIRST MIDDLE LAST)	DATE OF BIRTH (MM/DD/YYYY)	SEX
		☐ Male ☐ Female ☐ Decline to State
PATIENT STREET ADDRESS	**POSTAL CODE**	**PHONE NUMBER**

EMAIL ADDRESS

NEW INSULIN PUMP

☐ t:slim X2 insulin pump with **Control-IQ** technology ☐ t:slim X2 insulin pump with Basal-IQ technology

INFUSION SETS

☐ Patient Preference ☐ Other Product, If Applicable:

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

CURRENT DIABETES THERAPY: ☐ Insulin Pump (Use Current Settings) ☐ Multiple Daily Injections (Pump start orders required for insulin start; saline training ok if clinic protocol)

DIAGNOSIS ☐ Type 1 ☐ Type 2 — DATE OF DIAGNOSIS (MM/YYYY)

LAST 3 HbA1c RESULTS

(1) HbA1c : _____ Date : _____ (2) HbA1c : _____ Date : _____ (3) HbA1c : _____ Date : _____

☐ 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/or 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: 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 _____ mmol/L

☐ 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:

3 PRESCRIBER

PRESCRIBING PROVIDER NAME			MEDICAL LICENSE NUMBER
OFFICE STREET ADDRESS			PHONE NUMBER
CITY	PROVINCE	POSTAL CODE	FAX NUMBER
DIABETES EDUCATION CENTRE			EMAIL ADDRESS

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.

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 25 kilograms.

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