

STATEMENT OF MEDICAL NECESSITY AND PRESCRIPTION ORDER

Confidential Patient Health Information

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. Compatible Continuous Glucose Monitor (CGM) prescribed separately.

1 PATIENT ORDER INFORMATION

FULL NAME (FIRST MIDDLE LAST)					DATE OF BIRTH (MM/DD/YYYY)			SEX <input type="checkbox"/> Male <input type="checkbox"/> Female				
BILLING ADDRESS					ZIP CODE			PHONE NUMBER				
ORDER START DATE (MM/DD/YYYY)					TANDEM INSULIN PUMP WITH CONTROL-IQ+ TECHNOLOGY <input type="checkbox"/> Tandem Mobi <input type="checkbox"/> t:slim X2							
TANDEM MOBI (SELECT MULTIPLE SETS IF DESIRED)								T:SLIM X2 (SELECT MULTIPLE SETS IF DESIRED)				
AUTOSOFT XC				AUTOSOFT 30			TRUSTEEL	AUTOSOFT XC		AUTOSOFT 30		TRUSTEEL
INFUSION SET	AutoSoft XC, 5"/6mm	AutoSoft XC, 5"/6mm	AutoSoft XC, 23"/6mm	AutoSoft XC, 23"/6mm	AutoSoft 30, 23"/13mm	AutoSoft 30, 23"/13mm	TruSteel, 23"/6mm	AutoSoft XC, 23"/6mm	AutoSoft XC, 23"/6mm	AutoSoft 30, 23"/13mm	AutoSoft 30, 23"/13mm	TruSteel 23"/6mm
PACK SIZE	10	14	10	14	10	14	10	10	14	10	14	10
QUANTITY												
CARTRIDGE & INFUSION SET CHANGE EVERY ____ DAYS (REQUIRED): <input type="checkbox"/> 3 (10/MONTH) <input type="checkbox"/> 2 (14/MONTH) <input type="checkbox"/> 1 (30/MONTH)												
OTHER/SPECIFIC PRODUCT(S)							SIG			QTY		

2 TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

DIAGNOSIS CODE(S): <input type="checkbox"/> E10.9 <input type="checkbox"/> E10.65 <input type="checkbox"/> E10.649 <input type="checkbox"/> E11.9 <input type="checkbox"/> E11.65 <input type="checkbox"/> E11.649 <input type="checkbox"/> Other _____						LENGTH OF NEED <input type="checkbox"/> Lifetime (99 yrs) <input type="checkbox"/> Other: _____					
CURRENT THERAPY: <input type="checkbox"/> Multiple Daily Injections (MDI) <input type="checkbox"/> Durable Insulin Pump with tubing/infusion sets (IPT) <input type="checkbox"/> Disposable Insulin Delivery Device with patch/pod (IPT)						QUALIFICATIONS AND INDICATIONS AS PER MEDICAL RECORDS (CHECK ALL THAT APPLY): <input type="checkbox"/> Patient/caregiver completed a comprehensive diabetes program & is educated in diabetes management <input type="checkbox"/> Patient is routine with appointments <input type="checkbox"/> Blood glucose is checked as required or CGM used appropriately <input type="checkbox"/> Patient is pregnant or planning pregnancy <input type="checkbox"/> Patient/caregiver has the ability to operate and can use an insulin pump to manage blood glucose					
DIAGNOSED DATE <input type="checkbox"/> Newly Diagnosed <input type="checkbox"/> 3-6 months since diagnosis <input type="checkbox"/> 6+ months since diagnosis						PUMP START ORDER (PSO) At training, weight/TDI to be used in Profile Settings Calculator (MDI) or transfer of existing pump settings (IPT) unless box below is checked. <input type="checkbox"/> Prescriber to provide pump settings on PSO. Box must be checked if using non-U-100 analog insulin in pump.					
MEDICAL NECESSITY/REASON FOR THERAPY REPLACEMENT											

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 in anyone under the age of 2 years old with type 1 diabetes or under the age of 18 years old with type 2 diabetes. It should also not be used in patients who require less than a total daily insulin dose of 5 units of insulin per day or who weigh less than 20 pounds (9 kilograms), as those are the required minimum values needed for Control-IQ+ to operate safely.

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