



** 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	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 (E0784) <input type="checkbox"/> t:slim X2 Insulin Pump with Basal-IQ (Predictive Low Glucose Suspend)	CARTRIDGE CHANGE FREQUENCY <input type="checkbox"/> Every 3 days (Qty. 30) <input type="checkbox"/> Every 2-3 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 2-3 days (Qty. 40) <input type="checkbox"/> Every 2 days (Qty. 50) <input type="checkbox"/> Every 1 day (Qty. 90)	CGM SUPPLIES <input type="checkbox"/> A9276 Sensors – 365/365 (1 unit = 1 day) <input type="checkbox"/> A9277 Transmitter – 4/365 <input type="checkbox"/> A9278 Receiver – 1/365 <i>Directions for use: Site change per manufacturer recommendation, up to 90 days unless otherwise noted.</i>		
	INFUSION SETS <input type="checkbox"/> Patient Preference <input type="checkbox"/> Other Product, If Applicable: _____			INFUSION SET PREP <input type="checkbox"/> Skin Prep Wipes <input type="checkbox"/> Skin Transparent Dressing		
	PRESCRIPTION DURATION (MM/DD/YYYY) <input type="checkbox"/> Lifetime <input type="checkbox"/> Expire Date: _____					

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: _____					
	<input type="checkbox"/> Despite frequent therapy adjustments, the patient experiences suboptimal glycemic control - evidenced by wide glycemic fluctuations ranging from _____ to _____ mg/dL					
	<input type="checkbox"/> Patient is pregnant or planning pregnancy		<input type="checkbox"/> Hypoglycemia unawareness		<input type="checkbox"/> Nephropathy	
<input type="checkbox"/> Dawn phenomenon (AM hyperglycemia)		<input type="checkbox"/> Nocturnal hypoglycemia		<input type="checkbox"/> Gastroparesis		
<input type="checkbox"/> Extreme insulin sensitivity		<input type="checkbox"/> Retinopathy		<input type="checkbox"/> Hearing acuity requirement		
<input type="checkbox"/> Extreme insulin resistance		<input type="checkbox"/> Neuropathy		<input type="checkbox"/> Infusion site disconnect required		
<input type="checkbox"/> Other Conditions:						

3 PRESCRIBER	PRESCRIBING PROVIDER NAME		NPI		
	OFFICE STREET ADDRESS		PHONE NUMBER		
	CITY	STATE	ZIP CODE	FAX NUMBER	
	PRACTICE NAME AND NOTES			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.

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