TANDEM Diabetes Care

STATEMENT OF MEDICAL NECESSITY AND PRESCRIPTION ORDER

Confidential Patient Health Information

Fax Completed form To
Diabetic Supplies, Inc.
877-288-2520

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)

SEX ☐ Male ☐ Female ☐ Decline to State

PATIENT STREET ADDRESS

ZIP CODE

PHONE NUMBER

INSULIN PUMP
- ☐ t:slim X2 insulin pump with access to Control-IQ technology
- ☐ t:slim X2 insulin pump with access to Basal-IQ technology

LENGTH OF NEED
- ☐ Lifetime (i.e., 99 yrs)
- ☐ _____

ORDER INITIATION DATE (MM/DD/YYYY)

CARTRIDGE & INFUSION SET CHANGE FREQUENCY
- ☐ Every 3 days (Qty. 30)
- ☐ Every 2.25 days (Qty. 40)
- ☐ Every 2 days (Qty. 50)
- ☐ Every 1 day (Qty. 90)

CGM SUPPLIES
- ☐ Sensors – 365/365
- ☐ Transmitter – 4/365
- ☐ Receiver – 1/365

Directions for use: Site change per manufacturer recommendation, up to 90 days unless otherwise noted.

INFUSION SETS
☐ Patient Preference ☐ Other Product, If Applicable: _____

ADDITIONAL ITEMS NEEDED (E.G., WIPES, DRESSINGS, ETC.)

ICD-10 DIAGNOSIS CODE

HbA1c – RESULT %

DATE (MM/DD/YYYY)

☐ 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

☐ Blood glucose logs indicate blood glucose is checked as required or CGM used appropriately

CHECK APPLICABLE SECTIONS (SECTION 2 AND/OR 3)

2 ☐ Multiple Daily Injections (Pump start orders required for insulin start; saline training ok if clinic protocol)

- ☐ Variations in the day-to-day schedule and/or exercise prevent the achievement of successful glycemic control with multiple daily injections
- ☐ Patient performs multiple daily injections consisting of 3-4 or more injections per day and is able to self adjust insulin doses
- ☐ Despite frequent therapy adjustments, the patient experiences suboptimal glycemic control—evidenced by wide glycemic fluctuations

  ranging from _____ to _____ mg/dL

3 ☐ Insulin Pump (Use Current Settings)

- ☐ Current pump is out of warranty and/or its functionality no longer meets the patient's medical need (see "Mechanical or medical reasons for replacement:" for details)

Out of warranty date: _____

Mechanical or medical reasons for replacement:

4 Current therapy is failing due to:

OPTIONAL

- ☐ Patient is pregnant or planning pregnancy
- ☐ Dawn phenomenon (AM hyperglycemia)
- ☐ Hypoglycemia unawareness
- ☐ Nocturnal hypoglycemia
- ☐ History of ER/hospital visits: diabetic ketoacidosis (DKA), severe hypoglycemia,

  Other: _____ Date: _____
- ☐ Retinopathy
- ☐ Neuropathy
- ☐ Nephropathy

5 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.

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