TANDEM Diabetes Care

STATEMENT OF MEDICAL NECESSITY AND PRESCRIPTION ORDER

Confidential Patient Health Information

Fax completed form to **(619) 810-2304**
Other Fax:_____

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 ☐ Male ☐ Female
BILLING ADDRESS	ZIP CODE	PHONE NUMBER

ORDER START DATE (MM/DD/YYYY)	CARTRIDGE & INFUSION SET CHANGE EVERY __ DAYS (REQUIRED) ☐ 3 (qty 30) ☐ 2.25 (qty 40) ☐ 2 (qty 50) ☐ 1 (qty 90)
TANDEM INSULIN PUMP WITH CONTROL-IQ+ TECHNOLOGY ☐ t:slim X2 ☐ Tandem Mobi	INFUSION SET TYPE ☐ Patient Preference ☐ Other/specific product: _____

2 TO BE COMPLETED BY HEALTHCARE PROVIDER ONLY

DIAGNOSIS CODE(S):
☐ E10.9 ☐ E10.65 ☐ E10.649 ☐ E11.9 ☐ E11.65 ☐ E11.649 ☐ Other_____

LENGTH OF NEED
☐ Lifetime (99 yrs) ☐ Other:_____

CURRENT THERAPY:
- ☐ Multiple Daily Injections (MDI)
- ☐ Durable Insulin Pump with tubing/infusion sets (IPT)
- ☐ Disposable Insulin Delivery Device with patch/pod (IPT)

QUALIFICATIONS AND INDICATIONS AS PER MEDICAL RECORDS (CHECK ALL THAT APPLY):
- ☐ Patient/caregiver completed a comprehensive diabetes program & is educated in diabetes management
- ☐ Patient is routine with appointments
- ☐ Blood glucose is checked as required or CGM used appropriately
- ☐ Patient is pregnant or planning pregnancy
- ☐ Patient/caregiver has the ability to operate and can use an insulin pump to manage blood glucose

DIAGNOSED DATE
☐ Newly Diagnosed ☐ 3-6 months since diagnosis
☐ 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.
☐ 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 by anyone under the age of 2 years old. It should also not be used in patients who require less than 5 units of insulin per day or who weigh less than 20 pounds.

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