


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.

 Fax **both pages** of completed form to Tandem Pump Rx at **(877) 397-1217**.

PATIENT 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
EMAIL ADDRESS		

Please include a copy of the front and back of the patient's insurance card (both pharmacy and medical).

CLINICAL INFORMATION	
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/MDI TDI or Pump TDI will be used in Profile Settings Calculators to auto-calculate settings per AACE Guidelines, unless an alternative option is selected below: <input type="checkbox"/> Transfer of current pump settings (IPT) <input type="checkbox"/> Prescriber to provide customized pump settings on the PSO. This option must be selected if patient is using non-U-100 analog insulin in the pump, is pregnant, or is under 6 years of age.
MEDICAL NECESSITY/REASON FOR THERAPY REPLACEMENT	

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

PRESCRIPTION INFORMATION (CONTINUED NEXT PAGE)
ORDER START DATE (MM/DD/YYYY)

FULL NAME (FIRST MIDDLE LAST)	DATE OF BIRTH (MM/DD/YYYY)	PRESCRIBING PROVIDER NAME
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Select a Tandem insulin pump with Control-IQ + technology

<input type="checkbox"/>	Tandem Mobi SIG: Use as directed to administer insulin QTY: 1
<input type="checkbox"/>	t:slim X2 SIG: Use as directed to administer insulin QTY: 1

Select change frequency for infusion set

Select one option below. All packs include both insulin infusion sets and cartridges.

AutoSoft XC 5"/6mm — MOBI ONLY

<input type="checkbox"/>	Change every 3 days	10 Pack Rx Qty: 3 Packs (90-Day Supply)	10 Pack DME Qty: 30 (90-Day Supply)	Refills: 3
<input type="checkbox"/>	Change every 2 days	14 Pack Rx Qty: 3 Packs (84-Day Supply)	10 Pack DME Qty: 50 (90-Day Supply)	Refills: 3
<input type="checkbox"/>	Change daily	10 Pack Rx Qty: 9 Packs (90-Day Supply)	10 Pack DME Qty: 90 (90-Day Supply)	Refills: 3

AutoSoft XC 23"/6mm — MOBI OR T:SLIM X2

<input type="checkbox"/>	Change every 3 days	10 Pack Rx Qty: 3 Packs (90-Day Supply)	10 Pack DME Qty: 30 (90-Day Supply)	Refills: 3
<input type="checkbox"/>	Change every 2 days	14 Pack Rx Qty: 3 Packs (84-Day Supply)	10 Pack DME Qty: 50 (90-Day Supply)	Refills: 3
<input type="checkbox"/>	Change daily	10 Pack Rx Qty: 9 Packs (90-Day Supply)	10 Pack DME Qty: 90 (90-Day Supply)	Refills: 3

AutoSoft 30 23"/13mm — MOBI OR T:SLIM X2

<input type="checkbox"/>	Change every 3 days	10 Pack Rx Qty: 3 Packs (90-Day Supply)	10 Pack DME Qty: 30 (90-Day Supply)	Refills: 3
<input type="checkbox"/>	Change every 2 days	14 Pack Rx Qty: 3 Packs (84-Day Supply)	10 Pack DME Qty: 50 (90-Day Supply)	Refills: 3
<input type="checkbox"/>	Change daily	10 Pack Rx Qty: 9 Packs (90-Day Supply)	10 Pack DME Qty: 90 (90-Day Supply)	Refills: 3

TruSteel 23"/6mm — MOBI OR T:SLIM X2

<input type="checkbox"/>	Change every 2 days	10 Pack Rx Qty: 5 Packs (100-Day Supply)	10 Pack DME Qty: 50 (90-Day Supply)	Refills: 3
<input type="checkbox"/>	Change daily	10 Pack Rx Qty: 9 Packs (90-Day Supply)	10 Pack DME Qty: 90 (90-Day Supply)	Refills: 3

Other — DME ONLY

OTHER/SPECIFIC PRODUCT(S)	SIG	QTY	REFILLS

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.

By signing this form, I attest that I have discussed with the patient that, as part of the program, prescription fulfillment for a 90-day supply may be coordinated through an independent dispensing durable medical equipment ("DME") supplier. I have further explained that the patient's insurance coverage, benefit design, or program requirements may require fulfillment at a specific DME supplier. I confirm that I have discussed this process with the patient, including how dispensing locations may be determined, and have addressed any patient questions regarding prescription transfer and fulfillment. I further attest that the patient has consented to this process, including consent to being contacted and the transfer of the prescription to the fulfilling DME supplier.

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)	DATE (MM/DD/YYYY)
X	