

# NORTHEAST MEDICAL PRODUCTS, INC

AN INNOVA MEDICAL COMPANY

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INNOVA MEDICAL PRODUCTS



## DIABETIC SUPPLY RX FORM

DATE: \_\_\_\_\_ PATIENT NAME: \_\_\_\_\_

PATIENT ADDRESS: \_\_\_\_\_ PHONE: \_\_\_\_\_

PATIENT DOB: \_\_\_\_\_ HT: \_\_\_\_\_ WT: \_\_\_\_\_

LENGTH OF NEED: \_\_\_\_\_ ICD-10 CODE(S): \_\_\_\_\_

- Y N** A. Does the patient have Type 1 or Type 2 diabetes?
- Y N** B. Has the patient received sufficient training to use the CGM prescribed?
- Y N** C. Has the patient previously been on insulin treatment?
- Y N** D. Does the patient have a history of problematic hypoglycemia?
- Y N** E. Has the patient had recurring level 2 hypoglycemic events that persist despite multiple attempts to adjust medication or modify treatment plan?
- Y N** F. Does the patient have a history of one level 3 hypoglycemic event characterized by altered mental or physical state requiring third party treatment?
- Y N** G. Has the patient participated in fasting C-Peptide testing or tested positive for the Beta Cell Autoantibody?
- Y N** H. Has the patient completed a diabetes education program and taken at least 3 injections per day for at least the last 6 months AND has documentation of testing at least 4 times per day for at least 2 months?
- Y N** I. Does the patient have any of the following: HbA1c >7%, wide fluctuations in blood glucose levels prior to meals, OR dawn phenomenon with fasting blood sugars frequently exceeding 200mg/dl?

Based on the above information, the following items are needed by this patient for the stated length of need:

\_\_\_\_\_ **E2103/A4239 CONTINUOUS GLUCOSE MONITOR**

\_\_\_\_\_ **E0748 INSULIN PUMP**

\_\_\_\_\_ **A4224 INFUSION SET** \_\_\_\_\_ **A4230 W/ NEEDLE** \_\_\_\_\_ **A4231 W/O NEEDLE**

\_\_\_\_\_ **A4225/A4232 CARTRIDGE** \_\_\_\_\_ **A6257 DRESSINGS** \_\_\_\_\_ **A5120 PREP WIPES**

**\*\* PLEASE SUPPLY A COPY OF THE CLINICAL NOTES FROM FACE-TO-FACE VISIT \*\***

**I, THE UNDERSIGNED, CERTIFY THAT THE ABOVE PRESCRIBED EQUIPMENT AND/OR SUPPLIES ARE REASONABLE AND MEDICALLY NECESSARY AS PART OF TREATMENT FOR THIS PATIENT.**

Prescribing Physician's Name: \_\_\_\_\_

Prescribing Physician's Address: \_\_\_\_\_

Physician NPI: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Prescribing Physician's Signature: \_\_\_\_\_