adapthealth

INTERNAL USE	
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Please fax completed order form to 800-797-0381

Please include the following: insurance card, and previous 6 months of medical records in regards to diabetes.

Order Date: ____/____/____ Please initial and date any changes

Supplier: Solara Medical Supplies, an AdaptHealth Company. 2084 Otay Lakes Road, #102, Chula Vista, CA 91913		
Name:	DOB:	Home Phone:
Address:		Cell Phone:
Primary Insurance:		ID #

Continuous Glucose Monitors (CGM)

- ☐ **Abbott FreeStyle Libre 2 System & Supplies** qty 1: use as directed. qty 26: change sensor every 14 days or _____
- ☐ **Dexcom CGM & Supplies Receiver** qty 1: use as directed, Transmitter qty 4: 1 per 3 months, qty 36: 1 per 10 days or_____
- ☐ **Medtronic CGM & Supplies Transmitter** qty 1: 1 per year, Sensors qty 60: 1 per 7 days or_____

Additional Medical Information

Date of last office visit:____/____/____ The patient is testing _____ times per day.

Current insulin regimen: ☐ Insulin Pump ☐ Multiple Daily Injections ; ___ times per day ☐ Other (please specify):_____

☐ Patient is motivated and knowledgeable to use CGM, and adheres to a diabetes treatment plan.

Insulin Delivery Options

- ☐ **Insulin Pump** qty 1: use to deliver insulin. ☐New Pump ☐Upgrade Pump Manufacturer Preference:_____
  Date Out of Warranty _____/_____/_____ Malfunction Reason:_____
- ☐ **Insulin Pump Supplies** Infusion Set of Choice qty 50, Cartridge of choice qty 50: 1per 2 days or _____
- ☐ **Omnipod & Supplies** PDM of choice qty 1: use to activate pods. Omnipod of choice qty 50: 1per 2 days or _____
  ☐ New PDM ☐ Upgrade _____/_____/_____ Malfunction Reason:_____
- ☐ **V-GO 20 / 30 / 40** (circle ordered basal rate) V-GO qty 90: 1 per 24 hours or _____
- ☐ **InPen:** ☐ Humalog ☐ Novolog/Fiasp qty 2: Use with insulin cartridges. Any color choice.

The following conditions support the start of CSII with the insulin management system. Please mark all applicable condition and ensure they are supported in the patient's medical record.

- ☐ Patient is compliant with diabetes regimen recommended by healthcare provider (HCP)
- ☐ Day-to-day variations in work schedule, mealtime &/or activity level, which compound the degree of regimentation required to manage glycemia with multiple insulin injections.
- ☐ AM hyperglycemia (dawn phenomenon) in which fasting blood glucose (BG) levels often exceed 200 mg/dl.
- ☐ Patient (or patient's caregiver) has the ability to operate & use an insulin pump & supplies to treat & manage his/her BG.
- ☐ History of suboptimal glycemic control before or during pregnancy.
- ☐ History of nocturnal hypoglycemia
- ☐ Patient currently checks BG levels 4 or more times per day.
- ☐ Wide variations in pre-prandial BG levels (commonly exceeds 100 mg/dl).
- ☐ Patient has been on a program of multiple daily injections with frequent self-adjustment of insulin dose for at least 6 months prior to the initiation of the insulin pump.
- ☐ History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity, hypoglycemic awareness, nocturnal hypoglycemia &/or very low insulin requirements).
- ☐ Inadequate glycemic control despite appropriate adjustments in insulin therapy & compliance with frequent self-monitoring.
- ☐ Recurring episodes of severe hypoglycemia (<50 mg/dL)
- ☐ History of hypoglycemic unawareness
- ☐ Patient has completed a comprehensive diabetes education program.

☐ **Additional Supplies (cross out items not needed)**
Tapes/Wipes: Skin Prep Wipes qty 100: 1 per day, Removal Wipes qty 100: 1 per day, Film Dressing qty 100: 1 per day // Blood Strips /
Lancets/Meter: Test Strips qty 900 or_____/Lancets qty 900 or_____ of Choice: Test 10x per day, or _____, Meter qty 1: Use as directed //
Syringes/Pen Needles: Syringes qty 500 or_____: 6 per day, or _____ Pen needles qty 500 or_____: 6 per day, or _____ //
Ketone Strips/Meter: Urine qty 150: when ill or glucose above 240, Blood qty 150: when ill or glucose above 240, Meter qty 1: Use as directed by a Physician

Number of refills: _____ **or Lifetime** **HbA1c** _____

Diagnoses (check all that apply):

- ☐ E10.65 - Type 1 DM w/ Hyperglycemia ☐ E11.65 - Type 2 DM w/ Hyperglycemia ☐ Z79.4 - Long term (current) use of insulin
- ☐ E10.9 - Type 1 DM without complications ☐ E11.9 - Type 2 DM without complications ☐ Other (please specify):_____

Physician Signature:		Date:
Physician Name:		NPI:
Clinic:	Phone:	Fax: