Quickfill Pharmacy
18455 Burbank Blvd, Ste 105
Tarzana, CA 91326
Phone: (818) 457-4011 Fax: (818) 457-4053 Fax: (626) 508-7799

This is a physicians order for the Omnipod Insulin Management System. Please complete the information below to ensure that your patient on Omnipod insulin therapy. If there are any changes, please cross out incorrect information and update accordingly.

Patient Name: _____ _____ ***Gender*** ▢ ***Male*** ▢ ***Female***
Patient Address: _____
Patient DOB: _____
Patient Phone: ***Medicare ID:***

Physician Name: _____ _____
Physician Address: _____
Physician Phone: ***Physician Fax:***

Diagnosis Code: _____

<u>Physician Order:</u>

Dispense One Personal Diabetes Manager (PDM) as needed

▢ ***E0784/E0607 Personal Diabetes Manager***

Omnipod ▢ ***Dispense Lifetime Supply of Pods, Specify Otherwise:***_____

Replace Pod Every: ▢ ***72 hours (30 pods/90 days)*** ***Replace Pod Every:*** ▢ ***48 hours (50/pods/90 days)***

Physician Attestation: I certify that I am the Physician identified on this form. I have reviewed the Certificate of Medical Necessity. Any statement on my Letterhead attached hereto has been reviewed and signed by me. I certify that 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 listed and will be provided to the distributor upon request. A copy of this order will be retained as part of the patient's medical record.

Physician Signature _____ ***Date*** _____

Physician NPI _____

Please fax completed form to 818-457-4053. If you have any questions, call 818-457-4011.

OMNIPOD 5 DEXCOM G7/G6 INTRO KIT QUESTIONNAIRE

Patient Name: _____ _____
Patient Address: _____
Patient DOB: _____
Patient Phone:

Physician Name: _____ _____
Physician Address: _____
Physician Phone: ***Physician Fax:***

What is the diagnosis?

☐ ***Type 1 diabetes*** ☐ ***Type 2 diabetes*** ☐ ***Other (please describe)***

What is the rationale for treatment?

☐ ***Continuation of therapy on established patient.***
☐ ***Failure of self-monitoring (3-4 times daily testing frequency).***
☐ ***Hypoglycemia unawareness.***
☐ ***Insulin-treated with multiple daily injections (>3/day)***
☐ ***Recurrent episodes of severe hypoglycemia.***
☐ ***Requires frequent adjustments to therapy based on glucose results.***
☐ ***Uncontrolled A1C (>7%)***
☐ ***Other (please describe)***

Treatment start checklist:

☐ ***Contraindications to Omnipod 5 Dexcom G7/G6 Intro Kit have been ruled out.***
☐ ***Patient has completed comprehensive device and diabetes education.***
☐ ***(Renewal) Patients condition has improved with use of device.***

Notes:

All information is true and accurate to the best of my knowledge.

Prescribed Signature: _____ ***Date:*** _____

NPI: _____

- ***Please sign to validate.***

Please fax completed form to 818-457-4053. If you have any questions, call 818-457-4011.

Letter Of Medical Necessity

Re: _____ _____ ***DOB: _____***

Medication: Omnipod

To Whom it May Concern:

I am writing on behalf of my patient, _____ _____, to document the medical necessity of Omnipod for the treatment of Type-1 Diabetes mellitus with hyperglycemia (E10.65). This letter provides information about the patient's medical history, diagnosis, and a statement summarizing my treatment rationale.

History and Diagnosis: ***E10.65 - Type 1 Diabetes mellitus with hyperglycemia***

Patient has been attempting to treat diabetes through the method of multiple daily injections and other intermediate methods since the original diagnosis in _____. _____ _____ needs a tubeless insulin pump that is connected to a continuous glucose monitor to keep sugars controlled. Omnipod is the only option that meets those criteria's.

Treatment Rationale:

- ***Patient struggles with the following-***
- ***Failure to control Diabetes through multiple daily injections***
- ***Failure to keep (HbA1c) below 7%***
- ***History of recurring hyperglycemia***
- ***Wide fluctuations in blood glucose before mealtime, which includes frequent self-adjustments of insulin dosage***
- ***Dawn Phenomenon, with fasting blood sugars frequently exceeding 200 mg/dL***
- ***Etc; Duration: We would like to try Omnipod for 12 months. If there is success, we would like to continue onward for further amounts of time. He will be reevaluated every 3 months.***

Summary: In summary, Omnipod is medically necessary for this patient's medical condition. Please contact me if any additional information is required to ensure the prompt approval of Omnipod.

Sincerely,

_____ _____

Signature: _____

Please fax completed form to 818-457-4053. If you have any questions, call 818-457-4011.