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| Prescription Date: | |
| A. PATIENT INFORMATION | B. PHYSICIAN INFORMATION |
| Patient Name:  Address  City: State:  Phone:  DOB: | Physician:  Address:  City: State:  Phone:  Fax: NPI: |
| Please complete steps 1 through 6 below, and sign.  \*\*\*PLEASE FAX BACK TO 1-626-508-7799\*\*\* | |
| **1.** **TESTING FREQUENCY**  QD BID TID QID Other: \_\_\_\_\_x/day | |
| **2. ICD-10 DIAGNOSIS CODE:**  E10 E11 E11.65 Other: \_\_\_\_\_ | |
| **3**. **SUPPLIES ORDERED: (Please strike out the items not prescribed)**  Test Strips Lancing Device  Blood Glucose Alcohol Prep Pads  Control Solution Lancets  QUANTITY: Send 90 Day supplies, unless otherwise directed by insurance | |
| **4**. **INSULIN TREATED?** YES NO  Insulin Syringes: YES NO QD BID TID QID Other: \_\_\_\_\_  Pen Needles: YES NO QD BID TID QID Other: \_\_\_\_\_ | |
| **5. LENGTH OF NEED:** This order is good for one year from the signed date unless otherwise specified here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  REFILLS: 11 refills unless otherwise indicated here: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| **6. ALLERGIES**:  YES  NO  IF YES LIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |
| By signing, I certify (a) I am or was treating this patient on the effective date of this order: (b) This order accurately reflects this patient's diagnosis and condition and is substantiated by medical records. If prescribing a high-frequency regimen, I have seen this patients within the last 6 months to evaluate their medical condition: The patient or caregiver is (or) is scheduled to be trained in the use and administration of the above medications, and (d) I will make the original signed copy of this document a part of the patient's medical records and make it available to Medicare, Medicaid, and other insurers, that this pharmacy or any authorized agent, if requested.  Physician Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_  Physician Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ NPI: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ | |