

STATEMENT OF MEDICAL NECESSITY AND PRESCRIPTION ORDER

Confidential Patient Health Information

This form serves as a prescription and Statement of Medical Necessity for the Beta Bionics insulin infusion system and all related diabetes supplies to be provided by Beta Bionics or authorized distributors.

PATIENT ORDER INFORMATION (CHECK ITEM(S) BEING PRESCRIBED)				
PATIENT NAME (FIRST, MIDDLE, LAST)	SEX: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> _____	DATE OF BIRTH (MM/DD/YYYY)	PARENT/GUARDIAN (FIRST, LAST)	
PATIENT STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER
ITEM BEING PRESCRIBED: <input type="checkbox"/> iLet insulin pump	ORDER START DATE: Date ____/____/____ <small>(MM/DD/YYYY)</small>	LENGTH OF NEED:	iLet insulin pump: <input type="checkbox"/> Lifetime (i.e., 99 yrs.) <input type="checkbox"/> _____	Pump & CGM Supplies: <input type="checkbox"/> 1 year <input type="checkbox"/> _____
CARTRIDGE & INFUSION SET CHANGE FREQUENCY (choose one): <small>Consider TDD to ensure sufficient supplies; cartridge holds 165 units after priming.</small>		<input type="checkbox"/> Every 3 days: <small>TDD < ~50 units (Qty. 30 + 3 refills)</small>	<input type="checkbox"/> Every 2 days: <small>TDD ~50 to ~75 units (Qty. 50 + 3 refills)</small>	<input type="checkbox"/> Every 1 day: <small>TDD > ~75 units (Qty. 90 + 3 refills)</small>
CARTRIDGE & INFUSION SET SUPPLIES:	INSULIN CARTRIDGE: <input type="checkbox"/> iLet Cartridge Kit 10-pack CARTRIDGE ADAPTER: <input type="checkbox"/> iLet Connect Adapter 10-pack INFUSION SET TYPE (choose one): <input type="checkbox"/> Contact Detach: 6mm Steel Inset: 6mm Teflon cannula <input type="checkbox"/> Patient preference <input type="checkbox"/> needle, 23" tube length <input type="checkbox"/> 23" tube length <input type="checkbox"/> 32" tube length			
CGM TYPE (choose one):	FREESTYLE LIBRE 3 PLUS SUPPLIES <input type="checkbox"/> Sensors - change every 15 days. <small>(Qty. 6 + 3 refills)</small> <input type="checkbox"/> Reader (Qty. 1)	DEXCOM G6 SUPPLIES: <input type="checkbox"/> Sensors - change every 10 days. <small>(Qty. 9 + 3 refills)</small> <input type="checkbox"/> Transmitter - change every 90 days. <small>(Qty. 1 + 3 refills)</small> <input type="checkbox"/> Receiver (Qty. 1)	DEXCOM G7 SUPPLIES: <input type="checkbox"/> Sensors - change every 10 days. <small>(Qty. 9 + 3 refills)</small> <input type="checkbox"/> Receiver (Qty. 1)	
CURRENT THERAPY	ICD-10 DIAGNOSIS CODE: <input type="checkbox"/> Type 1 diabetes without complications (E10.9) <input type="checkbox"/> Type 1 diabetes with complications (E10.65) <input type="checkbox"/> Other: _____		WEIGHT: _____ (lbs) Date ____/____/____ <small>(MM/DD/YYYY)</small>	
	DIAGNOSIS DATE: ____/____/____ <small>(MM/YYYY)</small>		MOST RECENT HbA1c Result _____% Date ____/____/____ <small>(MM/DD/YYYY)</small>	
	<input type="checkbox"/> Patient/Caregiver has completed comprehensive diabetes education & is motivated to maintain optimal glucose control. <input type="checkbox"/> Patient/Caregiver has the ability to operate and can use an insulin pump to manage blood glucose. <input type="checkbox"/> Blood glucose logs indicate blood glucose is checked as required or CGM used appropriately.			
	<input type="checkbox"/> Multiple Daily Injections <input type="checkbox"/> Patient performs multiple daily injections consisting of 3-4 or more injections per day and is able to self-adjust insulin doses. <input type="checkbox"/> Variations in the day-to-day schedule and/or exercise prevent the achievement of successful glycemic control with multiple daily injections. <input type="checkbox"/> Despite frequent therapy adjustments, the patient experiences suboptimal glycemic control-evidenced by wide glycemic fluctuations ranging from _____ to _____ mg/dl.		<input type="checkbox"/> Insulin Pump <input type="checkbox"/> Current pump functionality no longer meets the patient's medical needs and/or is out of warranty. Mechanical or medical reasons for replacement: _____ _____ _____ Out of warranty date: _____ (or <input type="checkbox"/> n/a)	
DIABETES COMPLICATIONS (CHECK ALL THAT APPLY)	<input type="checkbox"/> Dawn phenomenon (AM hyperglycemia) <input type="checkbox"/> Hypoglycemia unawareness <input type="checkbox"/> Nocturnal hypoglycemia <input type="checkbox"/> Retinopathy <input type="checkbox"/> Nephropathy <input type="checkbox"/> Neuropathy <input type="checkbox"/> History of ER/hospital visits for: <input type="checkbox"/> DKA; <input type="checkbox"/> Severe Hypoglycemia; <input type="checkbox"/> Other: _____ Date(s): _____			
PRESCRIBER INFORMATION				
PRESCRIBING PROVIDER NAME		NPI#		PRACTICE NAME
OFFICE STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER
FAX NUMBER		EMAIL ADDRESS		
Prescribing Provider Attestation and Signature/Date				
<small>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 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 Beta Bionics® products I have prescribed herein. A copy of this order will be retained as part of the patient's medical record.</small>				
PRESCRIBER SIGNATURE: (SIGNATURE STAMPS ARE NOT ACCEPTABLE)			DATE (MM/DD/YYYY)	
X				