Beta Bionics

Fax Completed Form to: **1-800-786-0720**

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: ☐Male ☐Female ☐_____	DATE OF BIRTH (MM/DD/YYYY)	PARENT/GUARDIAN (FIRST, LAST)

PATIENT STREET ADDRESS	CITY	STATE	ZIP CODE	PHONE NUMBER

ITEM BEING PRESCRIBED:	ORDER START DATE:	LENGTH OF NEED:		
☐ iLet insulin pump	Date ____/____/____ (MM/DD/YYYY)	iLet insulin pump: ☐ Lifetime (i.e., 99 yrs.) ☐ _____		Pump & CGM Supplies: ☐ 1 year ☐ _____

CARTRIDGE & INFUSION SET CHANGE FREQUENCY (choose one): Consider TDD to ensure sufficient supplies; cartridge holds 165 units after priming.	☐ Every 3 days: TDD < ~50 units (Qty. 30 + 3 refills)	☐ Every 2 days: TDD ~50 to ~75 units (Qty. 50 + 3 refills)	☐ Every 1 day: TDD > ~75 units (Qty. 90 + 3 refills)

CARTRIDGE & INFUSION SET SUPPLIES:

INSULIN CARTRIDGE: ☐ iLet Cartridge Kit 10-pack

CARTRIDGE ADAPTER: ☐ iLet Connect Adapter 10-pack

INFUSION SET TYPE (choose one): ☐ Contact Detach: 6mm Steel needle, 23" tube length | Inset: 6mm Teflon cannula ☐ 23" tube length ☐ 32" tube length | ☐ Patient preference

CGM TYPE (choose one):

FREESTYLE LIBRE 3 PLUS SUPPLIES	DEXCOM G6 SUPPLIES:	DEXCOM G7 SUPPLIES:
☐ Sensors – change every 15 days. (Qty. 6 + 3 refills)	☐ Sensors – change every 10 days. (Qty. 9 + 3 refills)	☐ Sensors – change every 10 days. (Qty. 9 + 3 refills)
☐ Reader (Qty. 1)	☐ Transmitter – change every 90 days. (Qty. 1 + 3 refills)	☐ Receiver (Qty. 1)
	☐ Receiver (Qty. 1)	

CURRENT THERAPY

ICD-10 DIAGNOSIS CODE: ☐ Type 1 diabetes without complications (E10.9)
☐ Type 1 diabetes with complications (E10.65) ☐ Other: _____

WEIGHT: _____ (lbs)
Date ____/____/_____ (MM/DD/YYYY)

DIAGNOSIS DATE: ____/_____ (MM/YYYY)

MOST RECENT HbA1c Result_____% Date ____/____/____ (MM/DD/YYYY)

☐ Patient/Caregiver has completed comprehensive diabetes education & is motivated to maintain optimal glucose control.
☐ Patient/Caregiver has the ability to operate and can use an insulin pump to manage blood glucose.
☐ Blood glucose logs indicate blood glucose is checked as required or CGM used appropriately.

☐ Multiple Daily Injections
- ☐ Patient performs multiple daily injections consisting of 3-4 or more injections per day and is able to self-adjust insulin doses.
- ☐ Variations in the day-to-day schedule and/or exercise prevent the achievement of successful glycemic control with multiple daily injections.
- ☐ Despite frequent therapy adjustments, the patient experiences suboptimal glycemic control-evidenced by wide glycemic fluctuations ranging from _____ to _____ mg/dl.

☐ Insulin Pump
- ☐ 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 ☐ n/a)

DIABETES COMPLICATIONS (CHECK ALL THAT APPLY)

☐ Dawn phenomenon (AM hyperglycemia) ☐ Hypoglycemia unawareness ☐ Nocturnal hypoglycemia ☐ Retinopathy
☐ Nephropathy ☐ Neuropathy ☐ History of ER/hospital visits for: ☐ DKA; ☐ Severe Hypoglycemia;
☐ 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

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.

PRESCRIBER SIGNATURE: (SIGNATURE STAMPS ARE NOT ACCEPTABLE)	DATE (MM/DD/YYYY)
X	