ROSH PHARMACY- DIABETIC SUPPLY ORDER FORM
NPI: 1316481880

Patient Name		Patient D.O.B.	
Address			
Phone		Allergies	

Please complete Steps 1-9 of this form and fax **WITHIN** 24 **HOURS** to fax number: (832) 939-3560. You may alsocall the pharmacy directly to approve the prescription verbally to (832) 939-3550.

DOCTOR NAME		NPI:	
Address			
Phone		Fax	
Additional Notes			

1) TESTING FREQUENCY AND SIG: Use to test blood glucose: ☐ Other ___________

2) ICD-10 DIAGNOSTIC CODE: E11.9________ E11.65 ______ E 11.62 ______ OTHER _______

3) INSULIN TREATED: ☐ Other Insulin Used: ________________ Insulin Frequency:

SIG- Use along with insulin pen and/or insulin vial to inject insulin

INSULIN PEN NEEDLES FREQUENCY: ☐ Other _______

INSULIN SYRINGES FREQUENCY: ☐ Other ________

4) Supplies Ordered: Please cross out the items not prescribed.

☒ Test Strips ☒ Lancets ☒ Alcohol Prep Pad
☒ Blood Glucose Meter ☒ Lancet Device
☒ Insulin Pen Needles ☒ Insulin syringes

5) The prescription is approved for a 90-day supply, unless insurance prefers otherwise, for 1 year, or_________________refills.

Additional supplements requested by patient ______________________________________
☒ Omega 3 Ethyl Esters 1GM Qty: 360 capsules (90-day supply)
SIG: Take 2 capsules by mouth twice daily. Refills Authorized: ____________

The above information is true, accurate and complete to the best of my knowledge. I confirm that the patient has diabetes is/was being treated by me and is able to use the ordered items. The medical records jar this patient substantiate the prescribed testing frequency. The patient or caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items. Per Medicare/Insurance requirements, I will maintain a copy of this order in the patient's medical record. I agree to provide copies of supporting medical records as requested jar insurance review.

6) Dr. agrees that the rights of the patient to freedom of choice have been upheld.

7) Physician Signature: ____ Date:________________________

8) Physician Name (PRINT): ____ NPI: _______________________

9) Physician Assistant Name (if applicable): ____