

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 also call 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: Insulin Used: \_\_\_\_\_ Insulin Frequency:  OTHER \_\_\_\_\_

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
- Blood Glucose Meter
- Insulin Pen Needles
- Lancets
- Lancet Device
- Insulin syringes
- Alcohol Prep Pad

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

*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 for 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 for 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): \_\_\_\_\_