**GEM Edwards Pharmacy**
5640 Hudson Industrial Pkwy
Hudson, OH 44236-5011
Phone: (866) 552-5522 Fax: (844) 705-0156

# URGENT Prescription Order Request

**Date:** _____ **Patient's Name:** _____

**Patient's DOB:** _____ **Patient's Phone Number:** _____

**Physician Name:** _____ **Physician Fax Number:** _____

## Indicate any/all that are applicable

(if authorizing only one device, please cross out the other)

| | **Dexcom G6 Sensors** | **Dexcom G6 Transmitter** |
|---|---|---|
| **Rx:** | | |
| **Sig:** | Change every 10 days as directed to monitor blood glucose | Change every 3 months as directed to monitor blood glucose |
| **QTY:** | #9 sensors (84 day supply) | #1 transmitter |
| | **Refills:**_____ | **Refills:**_____ |

Please answer the below questions in order to help facilitate a timely and successful Prior Authorization if needed:

1. Diagnosis Code:_____
2. Has the patient been using a standard BGM and testing 4x or more daily? Y / N
3. Number of daily insulin injections:_____
4. Insulin regimen requires frequent adjustment based on standard BGM testing? Y / N
5. Is the patient able to use the CGM system as prescribed? Y / N
6. Has the patient had a face-to-face encounter with prescriber to evaluate glycemic control and to determine that the above criteria have been met? Y / N
7. Last office visit:___/___/_____
8. Is the patient currently using an insulin pump? Y / N Pump Make:_____ Pump Model:_____
9. Have any of the following prerequisites been met? (check all that apply)
   - ____ Recurring hypoglycemia
   - ____ Hypoglycemic unawareness
   - ____ Poor glycemic control despite testing at least 4 times daily
   - ____ Elevated HbA1c level at last test. If yes, last test date:___/___/_____

**Signature:** _____

**Print Name:** _____ **Date:** _____

NOTE: This prescription request is being sent on behalf of your patient. Please complete the required fields and return to GEM Edwards Pharmacy at the fax number stated above. By signing above, provider acknowledges that GEM Edwards Pharmacy may submit necessary Prior Authorization information to patient's third-party prescription insurance for above prescription medications/devices. If there are any questions regarding this request, please call our pharmacy at 1-866-552-5522. Thanks.