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 Name: _____ **Patient DOB:** _____

Patient Phone: _____

Patient Address: _____

Physician Name: _____

Practice Phone: _____ **Physician Fax Number:** _____

Practice Address: _____

Please complete all fields

Rx:

Medtronic Transmitter	Medtronic Sensor
☐ **Guardian Link 3 Transmitter (670G Pump)**	☐ **Guardian Sensor 3 (630G, 670G, and Standalone CGM)**
☐ **Guardian Link 3 Transmitter (770G Pump)**	☐ **Guardian Sensor 3 (770G Pump)**
☐ **Guardian 4 Transmitter (780G Pump)**	☐ **Guardian Sensor 4 (780G Pump)**
☐ **Guardian Connect Transmitter (Standalone CGM)**	

Sig:	Use with Medtronic sensor to monitor blood glucose as directed	Use as directed to monitor blood glucose. Change sensor every 5-7 days
Qty:	#1 Transmitter	#3 boxes (15 sensors)
Refills:	_____	_____

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

1. ICD-10 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:___/___/_____ and Value:_____

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.