

## **GEM Edwards Pharmacy**

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

## **URGENT Prescription Order Request**

Patient's DOB:		Patient's Name:  Patient's Phone Number:  Physician Fax Number:				
					Indicate any/all the (if authorizing only one device	nat are applicable e, please cross out the other)
				Rx:	Freestyle Libre 2 Sensors	Freestyle Libre 2 Reader
Sig:	Change every 14 days as directed to monitor blood glucose	Use as directed to monitor blood glucose				
QTY:	#6 sensors (84 day supply)	#1 reader				
	Refills:	Refills:				
Please answer	the below questions in order to help facilitate a t	timely and successful Prior Authorization if needed:				
3. Number of day 4. Insulin regim 5. Is the patient 6. Has the patient 7. Last office vi 8. Is the patient 9. Have any of ————————————————————————————————————	ent been using a standard BGM and testing 4x o aily insulin injections: en requires frequent adjustment based on stand t able to use the CGM system as prescribed? Y	dard BGM testing? Y / N / N to evaluate glycemic control and to determine that the above  p Make: Pump Model: that apply)  daily				
Signature:						
rint 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.