63931

Medtronic | inpen
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InPen™ Prescription/Start Orders

FAX TO: (1)

PATIENT MRN:

1 Patient Information (To be completed by prescriber)

☐ New InPen™ Order ☐ Reorder/ Upgrade ☐ Request Change in Therapy Mode

CONTACT		INSURANCE		
NAME(FIRST, MIDDLE, LAST)		INSURANCE NAME	PLAN PHONE	PATIENT
ADDRESS		RX BIN(REQUIRED)	RX	RX GROUP
DOB (MM/DD/YY)	PHONE	EMAIL		☐ ATTACH COPY OF RX CARD

2 Choose ONE InPen™

HUMALOG	OR	NOVOLOG/FIA SP
☐ InPen™(Humalog®)		☐ InPen™(Novalog®/Fiasp®)
☐ Blue qty ___ ☐ Grey qty ___		☐ Blue qty ___ ☐ Grey qty ___
☐ Pink qty ___		☐ Pink qty ___

NOTE: InPen™ requires a separate prescription for cartridges:
Humalog® U100 Cartridges (NDC 00002751659),
Novolog® U100 Cartridges (NDC 00169330312),
Fiasp® U100 Cartridges (NDC 00169320515)

3 Specify patient Therapy Settings (Required before first use of InPen™) - Section 5 of User Guide

Give a copy to the patient to input into InPen™ App.

A Insulin Settings

Maximum Calculated Dose ___ u

Duration of Insulin Action ___ hh:mm

TIME OF DAY - OFF

Time of Day **OFF**

Target Blood Glucose ___ mg/dL

Insulin Sensitivity Factor ___ mg/dL/u

OR

TIME OF DAY - ON

Time of Day ___ AM/PM

Target Blood Glucose ___ mg/dL

Insulin Sensitivity Factor ___ mg/dL/u

B Select ONE Meal Therapy Mode

☐ **Carb Counting**

Insulin to Carb Ratio ___ g/u

OR

*Time of Day ___ AM/PM

Insulin to Carb Ratio ___ g/u

***Time settings should match exact times in section A**

☐ **Meal Estimation**

	Low Carb	Medium Carb	High Carb
Breakfast	___ u	___ u	___ u
Lunch	___ u	___ u	___ u
Dinner	___ u	___ u	___ u
Snack	___ u	___ u	___ u

☐ **Fixed Dose**

Breakfast	___ u
Lunch	___ u
Dinner	___ u
Snack	___ u

C Long - Acting

Insulin Type ___

Doses per day ___

Dose 1

Usual Amount ___ u

Time ___ hh:mm

Dose 2

Usual Amount ___ u

Time ___ hh:mm

4 Complete, sign and fax this form to Companion Medical or retail pharmacy.

HCP agrees and attests that they have obtained all appropriate patient authorizations and consents to use and disclose patient data to Companion/ MDT and its agents so Companion/ MDT and its agents may provide services to patients in connection with their InPen™ prescription

DATE(MONTH/DAY/YEAR)*	HEALTH CARE PROVIDER SIGNATURE*		HEALTH CARE PROVIDER PRINT NAME*
FACILITY	ADDRESS	CITY	STATE
NPI	PHONE	FAX	EMAIL

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DO NOT FAX THIS PAGE

Prescribing Notes:

The InPen™System is not intended for anyone unable or unwilling to:

- Check blood glucose (BG) levels as recommended
- Maintain sufficient diabetes self-care skills
- Visit a healthcare provider regularly

Before Prescribing Verify/Review:

- Patient cognitive ability
- Patient familiarity with mobile devices
- Importance of range, alerts, and current time
- Importance of logging all fast-acting insulin and timing
- Crossing time zones / daylight savings time
- Split doses and doses over 30 Units

Policies:

Companion Medical Inc. will acquire from and/or release to the patient's healthcare team, and/or insurance company(s), and/or contracted distributors, and/or product development partners any information required for the purposes of healthcare operations. The patient will be informed of insurance coverage and estimated out-of-pocket expense prior to authorizing any shipment of product or any bills being sent. Below is the Policy for Using and Disclosing Protected Health Information. Companion Medical Customer Support may use this information to provide product support for Companion Medical products and services. Additional policies are posted on Companion Medical's website (including Privacy Policy and Terms of Service).

Policy for Using and Disclosing Protected Health Information

1. Uses and Disclosures. Companion Medical, Inc., its employees and its agents, including its distributors, product development partners, and trainers may use and disclose protected health information as described below. Companion Medical may contact me via telephone, mail, e-mail (including unencrypted e-mail), or by other means of communications.

2. Description of Information. Protected health information includes, but is not limited to, name and other personal information (including address), information from the InPen Start Orders, medical information, including information about diabetes and related medical conditions, medical records, and financial information (including information about insurance)

3. Purposes. Companion Medical may use and disclose protected health information for the following purposes:

(a) reviewing, using, and disclosing protected health information to coordinate or arrange delivery of diabetes-related supplies; (b) providing product updates, including regulatory notices relating to existing or future products; and (c) providing information that promotes medical products and/or services.

4. Expiration. This policy expires the later of when the patient is no longer a patient of Companion Medical, or ten years after the date of this start order.

5. Revocation. Acceptance of this policy may be revoked by sending a written request to Companion Medical, Inc., ATTN: Customer Support, 12230 World Trade Drive, Suite 100, San Diego, CA 92128, however, such revocation will not be effective with respect to protected health information that has already been used and/or disclosed

per this policy.

6. Treatment not Conditioned. Companion Medical will not deny treatment, products, or service based on acceptance of this policy.

7. Potential for Redisclosure. Information disclosed pursuant to this policy may be redisclosed by recipients and may no longer be protected by federal privacy laws.

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Companion Medical
T:844-843-7903 / F:1-877-444-2373

inpen-orders@companionmedical.com www.companionmedical.com

*REQUIRED FIELDS MUST BE FILLED OUT TO BE CONSIDERED A VALID PERSCRIPTION

LBL-00296-AW

☐ Q.R