FRD SPECIALTY PHARMACY INC.
6253 Foothill Blvd.
Tujunga, CA 91042
Phone: (818) 236-2500
Fax: (818) 236-2504

Diabetic Supply Prescription Referral Form

Date:	Ordering Contact:	Phone #:	Fax #:

PATIENT DEMOGRAPHICS

Patient Name:	**DOB:**	**Primary Phone #:**
Address:	**Apt. #:**	**City/State/Zip:**
Alternate Contact/Relationship:		**Alt. Phone #:**
Primary Insurance Plan:	**Ins. ID#:**	**Group #:**
Secondary Insurance Plan:	**Ins. ID#:**	**Group #:**

PRESCRIPTION ORDERS

REFILLS ☐ **X6** ☐ Other: _____

Diabetic Testing Supplies:

☐ Test Strips (qty #100) ☐ Syringes: _____ CC _____ G _____ mm *or* _____ in.
☐ Lancets (qty #100) ☐ Pen-needles: _____ G _____ mm *or* _____ in.
☐ Lancing Device ☐ Other Supplies: _____

Check only if brand or size substitutions are **not** allowed: ☐

Glucometer:

☐ Prodigy Meter Monitor Kit
☐ _____ meter provided at clinic
☐ Other: _____

Testing Frequency:

☐ 1 x per day
☐ 2 x per day
☐ 3 x per day
☐ _____ x per day

*****HIGH UTILIZATION*****

If ordering:

- **> 1 x per day** for **non-insulin** dependent
- **> 3 x per day** for **insulin**-dependent
- **> 4 x day** for **gestational diabetics**

Please complete the High Utilization narrative below ↓ for insurance approval.

Is the patient insulin dependent?

☐ No ☐ Yes, insulin pump
☐ Yes, injects _____ x per day (Syringes: x _____ and/or Pen-needles: x _____)

Diagnosis:

☐ E10.9 Type 1 DM w/o complications
☐ E11.9 Type 2 DM w/o complications
☐ E10.65 Type 1 DM with hyperglycemia
☐ E11.65 Type 2 DM with hyperglycemia
☐ O24.419 Gestational diabetes
*If gestational, est. due date (EDC):_____
☐ Other ICD-10 Code(s): _____

REQUIRED INFORMATION FOR HIGH UTILIZATION

Has the patient been seen in the last 6 months regarding their diabetes? ☐ Yes, date seen: _____ ☐ No ←
Is there documentation within the patient's chart (i.e. patient logs) to support the additional testing? ☐ Yes ☐ No ←
Check if patient recently had: ☐ Abnormal A1c ☐ Irregular blood glucose ☐ Medication adjustment ☐ Poor DM control

Physician's Narrative:

[UNABLE TO FILL PATIENT'S PRESCRIPTION WITHOUT PHYSICIAN'S SIGNATURE AND DATE]

Physician Printed Name: **NPI#:**

→ **Physician Signature: X** **Date:** ←

Please attach supporting documentation (chart notes, blood glucose logs) & fax to ***818-236-2504***

THANK YOU FOR CHOOSING FRD SPECIALTY PHARMACY