Walgreens

PLEASE INITIAL AND DATE ALL CHANGES

Diabetic Detailed Written Order

Fax form with prescriber's signature & date to 1-866-855-5888 **(toll free fax)**

1. Date of Order: _____

2. Patient Name: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone#: _____ **Gender:** _____ **Birth Date:** _____

3. Primary ICD-10 Diabetes Diagnosis: _____ **Diabetic Type:** _____

4. Diabetes Testing Supplies – Must Check ( )

Please dispense up to a 90-day supply of the following items at the patient's request. If your patient requests an item that is not checked, we will have to send you an additional form to sign & submit.

_____ Dispense all items listed below as indicated by patient and allowed by Medicare

Or

_____ Glucose Test Strips

_____ Lancets

_____ Meter

_____ Control Solution

_____ Lancet Device

_____ Meter Battery

5. Testing Frequency _____ **times/day**

6. Refills Authorized - Must Check( ) one

☐ 99 Refills

☑ Other _____

7. Treated with Insulin Injections? ____Y ____N

Using Infusion Pump to Administer Insulin? ____Y ____N

8. HBA1C Count _____

9. Medicare Utilization Guidelines

Medicare requires an explanation for testing more frequently than 1x day non-insulin or 3x day insulin treated; therefore, I confirm that I have evaluated this patient within the last six (6) months to assess their diabetes control and have noted below the reason(s) for high testing frequency.

_____

_____

My signature certifies that the above prescribed supplies/equipment are medically necessary for this patient's well-being. In my opinion the supplies are both reasonable and necessary to the accepted standards of medical practice in treatment of this patient's condition and are not prescribed as convenience supplies. By signing this form, I am confirming that the above information is accurate. The patient and/or caregiver understands how and is capable of using the blood glucose monitors test results to assure the patient's appropriate glycemic control.

10. Prescriber Name: _____ **NPI:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Phone _____ **Fax #:** _____

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Prescriber Signature: _____ **Date:** _____ **(Handwritten Signature and Date Required)**

- **Fax Form To: 1-866-855-5888 or mail original form to: Walgreens Medicare Processing, P.O. Box 4000 Danville, IL 61834-4000**
- **Questions? Contact the Walgreens Medicare Part B documentation department at: 1-888-281-0590 between the hours of 8:00-4:30 CST**
- **Please note that this document does not constitute the patient's Medical record. If this claim is audited by Medicare you could be required to provide additional documentation.**

Rx#: _____ Store#: _____