InPen Prescription / Start Orders

FAX TO: (1) 877-444-2373 (Companion Medical)
or (1)_____ (Retail Pharmacy)

1 Patient information (To be completed by prescriber)

☐ New InPen Order ☐ Request Change in Therapy Mode (If marked, fax directly to Companion Medical)

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

2 Choose ONE InPen™

HUMALOG
☐ InPen (Humalog®)
☐ Blue qty ____ ☐ Grey qty ____
☐ Pink qty ____

OR

NOVOLOG/FIASP
☐ InPen (Novolog®/Fiasp®)
☐ Blue qty ____ ☐ Grey 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.

I certify that I am the prescribing provider and have reviewed all of the order information above and have reviewed the prescribing notes on the back of these orders.

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

Companion Medical | inpen

****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.

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**