bedard
Pharmacy & Medical Supplies ☑
Phone: 207-783-1410 | Fax: 207-333-3271

InPen Prescription / New Order Form

PATIENT INFORMATION			
Name:		DOB:	Gender: ☐ Male ☐ Female
Street/City/State/Zip:			
Phone:	Email:		
Insurance Name:		ID #:	
Rx Group:		Rx BIN:	
Rx PCN:	Phone # (for providers):		☐ Attached Copy of Rx Card

PRESCRIPTION (Choose one InPen)

Humalog	NovoLog/Fiasp	
☐ InPen (Humalog®)	☐ InPen (NovoLog®/Fiasp®)	**Note: InPen requires a separate prescription for cartridges:**
☐ Blue Qty_____ ☐ Pink Qty_____ ☐ Grey Qty_____	☐ Blue Qty_____ ☐ Pink Qty_____ ☐ Grey Qty_____	Humalog® U100 Cartridges (NDC: 00002751659)
Refills:_____ Sig:_____	Refills:_____ Sig:_____	NovoLog® U100 Cartridges (NDC: 00169330312)
		Fiasp® U100 Cartridges (NDC: 00169320515)

PATIENT THERAPY SETTINGS

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

I certify that I am the prescribing provider and have reviewed all of the order information above and have reviewed the prescribing notes below.

PROVIDER INFORMATION		
Provider Name:	NPI #:	
Practice Name:	Phone #:	Fax #:
Street/City/State/Zip:		

Signature:_____ Date:_____

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

PLEASE FAX COMPLETED FORM TO BEDARD PHARMACY: 207-333-3271