Optum

OB Homecare Diabetes Services – Prescription for Home Administration

Fax signed form to: **866-252-4293** or **866-731-9011** or scan signed form to OBHIntake@optum.com

NOTE: Copy of current **INSURANCE CARD (front & back)** must accompany submission. Initiate & manage homecare per Optum Protocols (https://optum.com/obhomecareprotocols) OR call Optum @ **800-950-3963** for other orders.

Form Completed by (Name, Title, Phone): _____

Patient Name:				Phone:
Address:			City/St./Zip:	
DOB:	Due Date:	Ht:	Wt:	Email:
Preferred Language: ☐ English ☐ Other			Allergies:	
Pt. Current Location: ☐ Home ☐ Hospital (name)				
Insurance Info: (Carrier, Policy #, Phone #)				

Service Requested

Service start will occur upon verification, patient acceptance, and receipt of medication.

Patient to discontinue oral antidiabetic agent at start of insulin.

☐ **Diabetes Management via Insulin Injection**

☐ Check here if patient should continue oral agent

Choose One

☐ OPTUM to provide/dispense Novolin R and Novolin N vials.

☐ PATIENT to obtain insulin/medication through prescriber prescription.

Protocol

(Choose One)

☐ Per Optum protocol – Optum to calculate initial dose and adjust ongoing insulin requirements. Prescriber will receive patient specific information on plan of treatment after start of care.

☐ Select here if desires 1 hr. pp 110-140 (instead of 2 hr. pp 100-120)

☐ Do not use Optum protocol – contact prescriber for initial insulin dosing and ongoing orders or attach patient specific dosing.

☐ Follow prescriber signed protocol on file with Optum. (Available for high volume providers only.)

Criteria for Service

(Check all that apply)

☐ Patient needs support and resources for tight glycemic control.

☐ Glucose out-of-range with diet and/or oral agent.

☐ Highest Blood Glucose reported: _____

☐ Most recent A1C:

Value: _____

Date: _____

Initial Prescriber (Signature Required)

I certify that this patient is under my care and that the above services are medically necessary and are authorized by me with the above written plan of treatment. My signature acknowledges that (i) I have received and reviewed the protocol that accompanies this plan of treatment and understand and accept responsibility for the patient's care, and (ii) my state medical license is current and valid as indicated below. *** Please provide email for Plan of Care receipt/signature***

Prescriber Signature: _____ Print Name:_____

Select One: ☐ **Primary OB** ☐ **MFM** ☐ **Endocrinologist** ☐ **Hospitalist** (Patient will not start home care until ongoing provider sends signed Rx)

NPI#:_____ License #:_____ State:_____ Date:_____

Practice Name:		Office Contact:
Address:		City/St./Zip:
Phone:	Fax:	**MD Email:**

If ongoing care of this patient will be managed by another provider, complete the information below. As the prescriber, you are responsible for full care of this patient unless/until ongoing managing provider's prescription is received by Optum. At that time, all care responsibilities for this patient will be transferred to the alternate provider and the initial patient care prescription is discontinued, until such time physician noted above is responsible for patient.

Ongoing Provider's Name: _____ Phone: _____

FOR INTERNAL USE ONLY	Telephone Order From:		
	RBV by Optum Nurse:	Date:	Time:
	RX Reviewed by Optum Nurse:	Date:	