# OMNIPOD DASH® PUMP THERAPY ORDER FORM

Confidential: Protected Health Information

omnipod® DASH® INSULIN MANAGEMENT SYSTEM

30 DAYS of Freedom OMNIPOD® TRIAL PROGRAM

Patient Name _____ Date _____/_____/_____

Patient DOB _____ Patient Weight _____

Current Regimen _____ = _____ units Total Daily Dose (Pre-Pump)

## Dosing Calculation Section (optional)

| **Total Daily Dose (TDD) for pump calculations** | |
|---|---|
| **Pre-Pump TDD** _____ units | **Weight-based** _____ kg OR _____ lbs. |
| **Pre-Pump TDD x 0.75 = Pump TDD**<br>_____ (Pre-Pump TDD) units/day x 0.75 = _____ (Pump TDD) units | **Weight: kg x 0.5** or **lbs x 0.23**<br>_____ kg x 0.5 = _____ (Pump TDD) units OR _____ lbs. x 0.23 = _____ (Pump TDD) units |
| **If Pre-pump TDD and Weight-based are compared consider the following:** | ☐ Average value of Pre-Pump and weight based methods<br>☐ Hypoglycemic patients – use more conservative lower value<br>☐ Hyperglycemic patients, elevated A1c, pregnancy – use higher value |
| **Pump TDD = _____ units** | |
| **Basal Rate** | |
| **Total Daily Basal** *(Pump TDD x 50% = Total Daily Basal)* | _____ (Pump TDD) units/day x 0.5 = _____ (Total Daily Basal) units |
| **Initial Basal Rate** *(Total Daily Basal / 24 hours = Initial Basal Rate)* | _____ (Total Daily Basal) units/24 hours = _____ (Initial Basal Rate) U/hr |
| **Bolus Settings** | |
| **Insulin to Carb Ratio** *(450/Pump TDD = Insulin to Carb Ratio)* | 450/_____ (Pump TDD) units/day = _____ (Insulin to Carb Ratio) grams/unit |
| **Correction Factor** *(1700/Pump TDD = Correction Factor)* | 1700/_____ (Pump TDD) units/day = _____ (Correction Factor) mg/dL/unit |

**Initial Pump Settings (required)** ☐ **Transfer Pump Settings**

| **Basal Rates** | **Insulin to Carb Ratio** | **Correction Factor** | **Duration of Insulin Action** |
|---|---|---|---|
| 12:00 am - _____ = ____ U/hr | 12:00 am - _____ = ____ g/unit | 12:00 am - _____ = ____ mg/dL/unit | _____ hrs |
| _____ - _____ = ____ U/hr | _____ - _____ = ____ g/unit | _____ - _____ = ____ mg/dL/unit | |
| _____ - _____ = ____ U/hr | _____ - _____ = ____ g/unit | _____ - _____ = ____ mg/dL/unit | |
| _____ - _____ = ____ U/hr | _____ - _____ = ____ g/unit | _____ - _____ = ____ mg/dL/unit | |

**Max Basal Rate** = _____ U/hr

**Max Bolus** = _____ units

| | **Target BG** | **Correct Above** |
|---|---|---|
| 12:00 am - _____ = | _____ mg/dL | _____ mg/dL |
| _____ - _____ = | _____ mg/dL | _____ mg/dL |
| _____ - _____ = | _____ mg/dL | _____ mg/dL |

Target is the ideal BG number desired. Correct Above is the BG level above which a correction bolus is desired.

**Reverse Correction** (choose one)

☐ On ☐ Off

**Default Patient Instructions for Insulin Adjustments (required)**

**Adjust insulin settings if BGs are out of listed ranges:**

**Fasting/Pre-Meal:** _____ to _____ mg/dL

**Post Meal:** _____ to _____ mg/dL

**Bedtime:** _____ to _____ mg/dL

**Overnight:** _____ to _____ mg/dL

If overnight, fasting/pre-meal or bedtime BG is
- Above BG range – INCREASE BASAL by 10-20%
- Below BG range – DECREASE BASAL by 10-20%

If 2 hr post meal BG is
- Greater than 60 mg/dL above pre-meal BG – increase bolus amount by DECREASING Insulin to Carb Ratio by 10-20% to give MORE insulin
- Less than 30 mg/dL above pre-meal BG – decrease bolus amount by INCREASING Insulin to Carb Ratio by 10-20% to give LESS insulin

Elevated BG: Confirm trends 2-3 days before making adjustment
Low BG: Consider making adjustment immediately

Physician Specified Orders (if any): _____

Physician Name _____ Signature _____ Date _____

**Reference:** Grunberger, G, Abelseth, J, Bode, B., et al. Consensus Statement by the American Association of Clinical Endocrinologist/American College of Endocrinology Insulin Pump Management Task Force. *Endocrine Practice.* 2014; 20 (5), 463-489.

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omnipod® DASH® INSULIN MANAGEMENT SYSTEM

Date _____/_____/_____

Dear _____
*Dr. Name*

Below you will find current settings along with education topics reviewed with your patient _____.
*Patient Name*

I have instructed your patient to follow the self-management/insulin adjustment guidelines provided. Your patient has been instructed to call Insulet Customer Care for any technical/product assistance.

| **Initial Pump Settings entered in PDM *indicates settings provided by HCP on page 1** | | | |
|---|---|---|---|
| **Basal** | | | |
| Max Basal Rate* | | _____ U/hr | |
| Basal 1* | Time Segment<br>12:00 am - _____<br>_____ - _____<br>_____ - _____<br>_____ - _____ | <br>_____ U/hr<br>_____ U/hr<br>_____ U/hr<br>_____ U/hr | |
| Temporary Basal Rate | | ☐ On ☐ Off | |
| **Blood Glucose (BG)** | | | |
| BG Goal Limits | | Lower Limit _____ mg/dL<br>Upper Limit _____ mg/dL | |
| BG Meter | | ☐ Pair ☐ Skip | |
| **Bolus** | | | |
| Bolus Calculator | | ☐ On ☐ Off | |
| Target BG & Correct Above* | Time Segment<br>12:00 am - _____<br>_____ - _____<br>_____ - _____<br>_____ - _____ | Target<br>_____ mg/dL<br>_____ mg/dL<br>_____ mg/dL<br>_____ mg/dL | Correct Above<br>_____ mg/dL<br>_____ mg/dL<br>_____ mg/dL<br>_____ mg/dL |
| Minimum BG for Bolus Calcs | | _____ mg/dL | |
| Insulin to Carb (IC) Ratio* | Time Segment<br>12:00 am - _____<br>_____ - _____<br>_____ - _____<br>_____ - _____ | 1 unit of insulin covers<br>_____ g<br>_____ g<br>_____ g<br>_____ g | |
| Correction Factor* | Time Segment<br>12:00 am - _____<br>_____ - _____<br>_____ - _____<br>_____ - _____ | 1 unit of insulin decreases BG by<br>_____ mg/dL<br>_____ mg/dL<br>_____ mg/dL<br>_____ mg/dL | |
| Reverse Correction* | | ☐ On ☐ Off | |
| Duration of Insulin Action* | | _____ hours | |
| Maximum Bolus* | | _____ units | |
| Extended Bolus | | ☐ On ☐ Off | |
| **Education Reviewed:** | | | |
| ☐ Carb Counting | ☐ Site Selection/Rotation | ☐ Blood Glucose Testing | |
| ☐ Suggested Bolus Calculations | ☐ Site Adhesion | ☐ Hypoglycemia – Symptoms/Treatment | |
| ☐ Advanced Features<br>☐ Temp Basal<br>☐ Extended Bolus | ☐ Patient Insulin Adjustment<br>☐ Basal<br>☐ Bolus | ☐ Hyperglycemia – Symptoms/Treatment<br>☐ Ketone Testing | |
| ☐ Exercise | ☐ Sick Day Management | ☐ _____ | |

Additional Notes: _____

_____

_____

If you have any additional questions or concerns please feel free to contact me at _____

Trainer Name_____ (Trainer signature)_____ Date _____