OMNIPOD DASH® PUMP THERAPY ORDER FORM

Confidential: Protected Health Information

Patient Name *(print)*: _____

Date: ____/____/____ Patient Date of Birth: _____ 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
_____ units/day x 0.75 = _____ units
<small>Pre-Pump TDD</small>   <small>Pump TDD</small>

Weight: kg x 0.5 or lbs x 0.23
_____ kg x 0.5 = _____ units OR_____ lbs. x 0.23 =_____ units
                      <small>Pump TDD</small>   <small>Pump TDD</small>

If Pre-pump TDD and Weight-based are compared, consider the following:

☐ Average value of Pre-Pump and weight based methods
☐ Hypoglycemic patients – use more conservative lower value
☐ Hyperglycemic patients, elevated A1c, pregnancy – use higher value

Pump TDD = _____ units

BASAL RATE

Total Daily Basal *(Pump TDD x 50% = Total Daily Basal)*

_____ units/day x 0.5 = _____ units
<small>Pump TDD</small>   <small>Total Daily Basal</small>

Initial Basal Rate *(Total Daily Basal / 24 hours = Initial Basal Rate)*

_____ units/24 hours = _____ U/hr
<small>Total Daily Basal</small>   <small>Initial Basal Rate</small>

BOLUS SETTINGS

Insulin to Carb Ratio *(450/Pump TDD = Insulin to Carb Ratio)*

450/_____ units/day = _____ grams/unit
      <small>Pump TDD</small>   <small>Insulin to Carb Ratio</small>

Correction Factor *(1700/Pump TDD = Correction Factor)*

1700/_____ units/day = _____ mg/dL/unit
        <small>Pump TDD</small>   <small>Correction Factor</small>

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	

	Target BG	Correct Above	Reverse Correction *(choose one)*
Max Basal Rate = _____ U/hr	12:00 am - _____ = _____ mg/dL	_____ mg/dL	
	_____ - _____ = _____ mg/dL	_____ mg/dL	☐ On ☐ Off
Max Bolus = _____ units	_____ - _____ = _____ mg/dL	_____ mg/dL	

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

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 *(print)*:_____ Physician 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.

OMNIPOD DASH® PUMP THERAPY ORDER FORM

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Date: _____/_____/_____

Dear _____ ,
Doctor Name (print)

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

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 12:00 am - _____ _____ - _____ _____ - _____ _____ - _____	_____ U/hr _____ U/hr _____ U/hr _____ U/hr
Temporary Basal Rate		☐ On ☐ Off

BLOOD GLUCOSE (BG)

BG Goal Limits		Lower Limit _____ mg/dL Upper Limit _____ mg/dL
BG Meter		☐ Pair ☐ Skip

BOLUS

Bolus Calculator		☐ On ☐ Off	
Target BG & Correct Above*	Time Segment 12:00 am - _____ _____ - _____ _____ - _____ _____ - _____	**Target** _____ mg/dL _____ mg/dL _____ mg/dL _____ mg/dL	**Correct Above** _____ mg/dL _____ mg/dL _____ mg/dL _____ mg/dL
Minimum BG for Bolus Calcs		_____ mg/dL	
Insulin to Carb (IC) Ratio*	Time Segment 12:00 am - _____ _____ - _____ _____ - _____ _____ - _____	**1 unit of insulin covers** _____ g _____ g _____ g _____ g	
Correction Factor*	Time Segment 12:00 am - _____ _____ - _____ _____ - _____ _____ - _____	**1 unit of insulin decreases BG by** _____ mg/dL _____ mg/dL _____ mg/dL _____ 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
    ☐ Temp Basal
    ☐ Extended Bolus
	☐ Patient Insulin Adjustment
	    ☐ Basal
	    ☐ Bolus
		☐ Hyperglycemia – Symptoms/Treatment
		    ☐ 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 *(print)*: _____   Trainer Signature : _____   Date: _____