

Confidential Fax

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| Patient: | DOB: | Date: |
| Address: | Phone: | |

Omnipod DASH®

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|---|----------------------|
| <p><u>Omnipod DASH PDM Kit (Gen 4)</u> NDC 08508-2000-00 QTY: 1 Days Supply: 30 Days Refills: 0 SIG: Use as directed with DASH Pods</p> | R_x |
|---|----------------------|

Fax this prescription authorization to 1-866-344-1450

Prescriber Signature: _____ **Authorized Date:** _____

Printed Name: _____ **Prescriber NPI:** _____

Office Phone Number: _____

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