Written Order and CMN for Insulin Pumps and Pump Supplies

PATIENT INFORMATION:		
Name:		
Address:		
City, ST, Zip:		
Phone:	Date of Birth:	Order Date:

DOCTOR INFORMATION:	
Name:	
Address:	
City, ST, Zip:	
Phone:	Fax:
NPI:	License #:

Effective Date: ______________ **(good for 12 months)**

Please complete all sections below:

1. What is the patient's ICD10 Diagnosis Code: ______________________
2. Last office visit: ______________________________
3. ☐ YES My records indicate that patient has completed a comprehensive diabetes education program.
4. ☐ YES Patient has been on a program of at least 3 injections per day, with frequent self-adjustments of insulin doses for at least 6 months prior to initiation of the insulin pump?
5. ☐ YES My records document that patient has documented frequency of glucose self-testing an average of 4 times per day OR has been using a Continuous Glucose Monitor (CGM) during the 2 months prior to the initiation of the insulin pump?
6. ☐ YES My records indicate a history of recurring hypoglycemia, nocturnal hypoglycemia, or hypoglycemia unawareness?
7. ☐ YES Patient has wide fluctuations in blood glucose before meals?
8. What is the total daily dose of insulin that your patient is using? _________ units/day
9. ☐ YES My records indicate that patient has dawn phenomenon with FBS frequently exceeding 200mg/dl.
10. ☐ YES My records indicate a history of severe glycemic excursions.
11. ☐ YES Is there a Glycosylated hemoglobin HbA1c level: _________% Test

This prescription is valid for all items below and are required for proper use of the Insulin Pump system. Items provided are based on the model and brand that the patient has been prescribed.

Insulin Pump – E0784/E1399 (1 insulin pump)
If pump is a rental through the patient's insurance, this prescription is valid for all months of the rental period.

Remover Wipes – A4456 (30/month)

Infusion Sets – A4230/A4231 (30/month), A4221/A4224 (1/week)

Dressings A6257 (30/month)

Ketostix – A4250 (30/month)

Preps – A5120 (30/month)

Reservoirs – K0552/A4232/A4225 (30/month)

Pods – A9274 (30/month)

If there are specific instructions, list here: ____

I certify the medical necessity of these items for this patient. The medical information on this form and any statement on my letterhead attached hereto has been completed by me or my employee and reviewed by me. The foregoing information is true, accurate, and complete, and I understand that my falsification, omission, or concealment of material fact may subject me to civil or criminal liability. I certify that I am a physician who manages multiple patients on continuous subcutaneous insulin therapy and work closely with a team of nurses, diabetes educators, and dietitians knowledgeable in insulin pump therapy and evaluating the patient every 3 months.

Physician Signature: no stamps please	Date:

Prescription valid for one year from signature date.

Return to: **FAX: (502) 657-0237**

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