Written Order and CMN for Insulin Pump and Insulin Pump Supplies

PATIENT INFORMATION:		
Name:		
Address:		
City, ST, Zip:		
Phone:	**Date of Birth:**	**Account #:**

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

PRODUCT INFORMATION *(please check the items that you are NOT prescribing):*

Items & quantities to be dispensed per month (insurance quantity limitations will apply).

- ☐ **Insulin Pump** – E0784 (1 pump)
- ☐ **Dressings** – A6257 (30)
- ☐ **Preps** – A5120 (30)
- ☐ **Remover Wipes** – A4456 (30)
- ☐ **Ketostix** – A4250 (30)
- ☐ **Reservoirs** – K0552/A4232/A4225 (30)
- ☐ **Infusion Sets** – A4230/A4231 (30)
- ☐ **Infusion Sets** – A4221/A4224 (1/week)
- ☐ **Pods** – A9274 (30)

If there are any specific instructions, list here:_____

MEDICAL INFORMATION *(please check and/or complete the appropriate responses):*

1. YES ☐ NO ☐ All of the items listed above are being prescribed for this patient (upon their request).
2. YES ☐ NO ☐ My records indicate that patient has completed a comprehensive diabetes education program.
3. YES ☐ NO ☐ 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?
4. YES ☐ NO ☐ My records document that patient has documented frequency of glucose self-testing an average of 4 times per day during the 2 months prior to the initiation of the insulin pump?
5. YES ☐ NO ☐ My records indicate that patient has been determined to be independent with insulin management and has support to stay motivated to achieve glycemic control?
6. YES ☐ NO ☐ Patient has been taught carbohydrate counting and follow a dietary regimen?
7. YES ☐ NO ☐ My records indicate that the patient has a history of poor glycemic control contributing to preconception complication and/or is pregnant?
8. YES ☐ NO ☐ My records indicate that day to day schedule variations such as mealtimes, work schedule, or activity level confound the degree or regimentation required to self-manage glycemia?
9. YES ☐ NO ☐ My records indicate a history of recurring hypoglycemia, nocturnal hypoglycemia, or hypoglycemia unawareness?
10. YES ☐ NO ☐ Patient has wide fluctuations in blood glucose before meals?
    Glucose range levels are _____ to _____
11. What is the total daily dose of insulin that your patient is using? _____ units/day
12. YES ☐ NO ☐ My records indicate that patient has dawn phenomenon with FBS frequently exceeding 200mg/dl.
13. YES ☐ NO ☐ My records indicate a history of severe glycemic excursions.
14. YES ☐ NO ☐ Is there a Glycosylated hemoglobin HbA1c level: _____% Test
15. Diagnosis Code: Type 1: _____ Type 2: _____ Other: _____
16. Date of Patient's Last Office Visit:

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**:

SIGNATURE VALID 1 YEAR FROM SIGNATURE DATE

or return to: **FAX: (502) 657-0237**

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