Written Order and CMN for Insulin Pump and Insulin Pump Supplies

PATIENT INFORMATION:

Name:		
Address:		
City, ST, Zip:		
Phone:	*Date of Birth:*	*Account No.*

DOCTOR INFORMATION:

Name:	
Address:	
City, ST, Zip:	
Phone:	*Fax:*

Please check off any 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/A4222/A4225 (30)
- ☐ **Infusion Sets** – A4230/A4231/A4224 (30)
- ☐ **Infusion Sets** – A4221 (1/week)
- ☐ **Pods** – A9274 (30)

Medical Information: (please select the appropriate response)	
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 meal times, 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. ☐ **YES** ☐ **NO**	My records indicate that patient has dawn phenomenon with fasting blood sugars frequently exceeding 200mg/dl
12. ☐ **YES** ☐ **NO**	My records indicate a history of severe glycemic excursions
13. ☐ **YES** ☐ **NO**	Is there a Glycosylated hemoglobin HbA1c level: _____% Test
14. Diagnosis Code:	TYPE I: _____ TYPE II: _____ Other:_____
15. Patients 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 review 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 educator, dieticians knowledgeable in insulin pump therapy and evaluating the patient every 3 months.

Physician Signature: _____ **Date:** _____

NO STAMPS PLEASE

NPI:_____ **UPIN:**_____

SUBMIT FORM

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

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