

This form functions as a Prescription and Letter of Medical Necessity

Patient Name: _____ **DOB:** ____/____/____ **Sex:** Male Female
Home Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Patient Phone: (Day) _____ (Alt) _____ **HICN #** _____

The PATIENT listed above has requested that we provide Diabetes testing supplies to assist in their health management program. Please complete items **1 thru 4** carefully, provide signature and date, and FAX completed form to
1-866-317-0829

Doctor Name: _____ **Office Contact:** _____
Doctor Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Doctor Phone: _____ **FAX:** _____ **UPIN #** _____ **Medicaid #** _____

----- PRESCRIPTION -----

EXISTING CONDITIONS listed support the starting and/or continuation of insulin pump therapy: *(check all that apply)*

- 1.**
- Patient is motivated to maintain optimal control of his/her diabetes.
 - Patient's current insulin pump is out of warranty.
 - Patient requires newer technology that is not available on their current pump.
 - Patient has the ability to operate and can use an insulin pump to manage their blood glucose.
 - Patient performs four (4) or more self-monitored blood glucose tests per day, TPD = _____
 - Patient has been doing MDI consisting of _____ injections per day.

CLINICAL INDICATIONS for insulin pump therapy: *(check all that apply)*

- 2.**
- Wide fluctuations in blood glucose values _____ to _____ mg/dl.
 - Extreme insulin sensitivity
 - Nocturnal hypoglycemia
 - Pregnancy or preconception planning
 - Nephropathy
 - Retinopathy
 - Other lab values _____ BUN _____ Creatinine _____ Microalbuminuria
 - Other conditions: _____
 - AM hyperglycemia (dawn phenomenon)
 - Hypoglycemia unawareness
 - Diabetes ketoacidosis
 - Recent A1c values _____% _____%
 - Neuropathy
 - Uncontrolled glycemic control post-renal transplant

PUMP PRESCRIPTION INCLUDES: *(check all that apply)*

- 3.**
- Insulin pump and related software
 - Infusion sets: (90 day supply) brand of patient's choice
 - Insulin cartridges
 - Normal Saline
 - All other necessary supplies _____

PUMP TRAINING: *(check all that apply)*

- Teaching will be completed by physician's office staff
- Please arrange for teaching by contracted Personal Pump Trainer

MAXIMUM DURATION: LIFETIME or if other _____

4. I state that: **(a)** I am or was treating this patient for diabetes mellitus on the effective date of this order, **(b)** This statement accurately reflects this patient's diagnosis and condition and is substantiated by my medical records, and **(c)** I will make the original signed copy of this document a part of this patient's medical records and make it available to Medicare, Medicaid, and other insurers, Support Plus Medical, Inc., or any authorized agent, if requested.

SIGNATURE: _____ **NPI #** _____ **DATE:** ____/____/____