

CERTIFICATE OF MEDICAL NECESSITY

New Pump

Upgrade Pump

Pump Supplies

Diabetic Supplies

Is this a Pediatric Model Pump?

Is this a Pediatric Model Pump?

- Infusion sets
- Pump syringes/reservoirs
- Related supplies
(IV preps & adhesives, tape, replacement batteries)

- Glucose Meter
- Test strips
- Lancets
- Related supplies (control solution, alcohol swabs, insulin syringes, glucose tabs)

REAL Time Starter Kit
Guardian REAL Time

Replacement Transmitter
Sensors

PATIENT INFORMATION

Patient Name:		Sex:	SSN:	DOB:
Address		Phone (day)		
City/St/Zip		Phone (night)		
Subscriber Name <i>(Please send copy of ins. card)</i>		Subscriber Name <i>(Please send copy of ins. card)</i>		
Primary Insurance		Secondary Insurance		
Group #	Policy #	Group #	Policy #	
Insurance Phone #		Insurance Phone #		
Employer				

STATEMENT OF MEDICAL NECESSITY

# Insulin shots/day in last 6 months:	# Glucose checks/day:
HbA1c: Date:	Fluctuation of blood glucose values:

Current Diagnosis and Diabetic Complications:

250.00 250.01 250.02 250.03 Additional diagnosis:

Insulin Reaction Notes:

Additional Notes:

Has the member completed a diabetes education program? Yes No

Has the member been on a program of multiple daily injections of insulin with frequent self-adjustments of insulin dose for at least 6 months prior to the initiation of the insulin pump? Yes No

I certify that the above patient demonstrates one or more of the following *(Please check all that apply)*:

- A. Hemoglobin HbA1C level is 7.0% or 1% over upper range of normal
- B. History of severe glycemic excursions (commonly associated with brittle diabetes, hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity and/or very low insulin requirements.
- C. Wide fluctuations in preprandial BG levels (e.g., levels commonly exceed 100 mg/dl)
- D. Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dl.
- E. Day-to-day variations in work schedule, mealtimes and/or activity level, which confound the degree of regimentation required to self-manage glycemia with multiple insulin injections.
- F. History of suboptimal glycemic control before or during pregnancy.
- G. Suboptimal glycemic and metabolic control after renal transplantation.
- H. Poor glycemic control evidenced by CGMS sensing.

Is this a replacement pump? Replacement transmitter? : Please provide reason:

SUPPORTING CRITERIA *(Please check all that apply)*:

- Member has been hospitalized or required paramedical treatment for low blood sugar
- Member has demonstrated ability to self-monitor blood glucose levels > 4x/day
- Member is motivated to achieve and maintain improved glycemic control

PHYSICIAN INFORMATION

Physician:	Office Contact:
Hospital/Clinic:	Phone #:
Address:	Fax #:
City/State/Zip:	NPI #:

This document serves as a Prescription and Statement of Medical Necessity for the above referenced patient for a Medtronic MiniMed insulin infusion pump and/or any items designated above.

I certify that I am the physician identified in the above section, and I certify that the medical necessity information contained in this document is true, accurate and complete, to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact in that section may subject me to Civil or criminal liability.

Signature: _____

Date: _____