Phone: 207-784-3700 | Fax: 207-795-7622

CERTIFICATE OF MEDICAL NECESSITY
INSULIN PUMP & SUPPLIES

Insulin Infusion Pump (E0784) ☐ New Pump ☐ Replacement Pump

Pump Model:	CGM Components:	☐ Pump Supplies	☐ Diabetic Supplies
☐ t:slim X2 with Basal-IQ Technology	☐ A9278 Receiver (1/365)	Infusion Sets, Reservoirs, IV Preps & Adhesives, Replacement Batteries	Glucose meter test strips, lancets, control solution
☐ t:slim X2 with Control-IQ Technology	☐ A9276 Sensors (365/365 (1 unit = 1 day))		
☐ Other:___________________________	☐ A9277 Transmitter (4/365)		

PATIENT INFORMATION

Patient Name:	Gender:
Address:	DOB:
City/State/Zip:	Phone:

STATEMENT OF MEDICAL NECESSITY

# Multiple Daily Injections per day		# SMBG/day to per day
HbA1C:	Date:	Fluctuation of blood glucose values: to mg/dl
Member to change infusion sets every three (3) days (or every _______ day(s))		Number of refills:

Current Diagnosis and Diabetic Complications

Type 1: ☐ E10.9 ☐ E10.65 **Type 2:** ☐ E11.9 ☐ E11.65 **Additional diagnosis:**____

Complications/Insulin Reaction Notes:

SUPPORTING CLINICAL INDICATIONS

- ☐ 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, extreme insulin sensitivity and/or very low insulin requirements
- ☐ C. Wide fluctuations in prepandial 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 72 hour CGMS sensing trial

Is this a replacement pump? ☐ Please provide reason:

SUPPORTING CRITERIA

- ☐ I. Patient has completed comprehensive diabetes education
- ☐ J. Patient has demonstrated ability to self-monitor blood glucose levels as recommended by Physician
- ☐ K. Patient 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 an Insulin Pump and related supplies.

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, and I understand that any falsification, omission, or concealment of material fact in that section may subject me to civil or criminal liability.

Signature:____ Date:____________________