bedard MEDICAL SUPPLIES

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

# MEDTRONIC INSULIN PUMP AND SUPPLIES PRESCRIPTION & CERTIFICATE OF MEDICAL NECESSITY

| Order Type | Complete System | Individual Components | CGM Products | Pump Supplies | Diabetic Supplies |
|---|---|---|---|---|---|
| ☐ New Pump<br>☐ Replacement Pump<br>***Current Pump Model:***<br>_____<br>***Reason for Replacement:***<br>_____ | ☐ MiniMed 770G System<br>☐ MiniMed 630G System<br>• Insulin Pump (E0784)<br>• Transmitter (A9277) (4/365)<br>*For use with sensors to check blood glucose daily*<br>• Sensors (A9276) (365/365)<br>*Change sensors every 10 days* | Insulin Pumps (E0784)<br>☐ MiniMed 770G<br>☐ MiniMed 630G | ☐ Receiver (A9278) (1/365)<br>*Used to check blood glucose daily*<br>☐ Sensors (A9276) (365/365)<br>*Change sensors every 10 days*<br>☐ Transmitter (A9277) (4/365)<br>*For use with sensors to check blood glucose daily* | ☒ Infusion Sets, Reservoirs/ Cartridges, Syringes, IV Preps & Adhesives, Transparent Dressings | ☒ Glucose Meter Test Strips, Lancets, Control Solution, Insulin Syringes, Alcohol Swabs |

| **PATIENT INFORMATION** | | |
|---|---|---|
| Patient Name: | DOB: | Gender: ☐ Male ☐ Female |
| Street: | | |
| City/State/Zip: | | Phone: |

| **STATEMENT OF MEDICAL NECESSITY (PHYSICIAN USE ONLY)** | |
|---|---|
| **Diagnosis (ICD-10): Type 1:** ☐ E10.9 ☐ E10.65 **Type 2:** ☐ E11.9 ☐ E11.65 ☐ **Additional diagnosis:** | |
| # of insulin shots/day in the last 6 months: | Blood glucose value range: to mg/dL |
| Latest HbA1c Result: Date: | Glucose checks/day: to |
| # Multiple Daily Injections per day: | # SMBG/day: to per day |
| Member to change infusion sets every three (3) days, or every _____ day(s) | Number of refills: 11 |

| **SUPPORTING CLINICAL INDICATIONS (PHYSICIAN TO CHECK ALL THAT APPLY)** |
|---|
| ☐ Recurrent episodes of severe hypoglycemia with BG's less than 50 mg/dL. Frequency of episodes: |
| ☐ Hemoglobin HbA1C level is 7.0% or 1% over upper range of normal |
| ☐ History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity and/or very low insulin requirements |
| ☐ Wide fluctuations in prepandial BG levels (e.g., levels commonly exceed 100 mg/dL) |
| ☐ Dawn phenomenon where fasting blood glucose level often exceeds 200 mg/dL |
| ☐ 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 |
| ☐ History of suboptimal glycemic control before or during pregnancy |
| ☐ Suboptimal glycemic and metabolic control after renal transplantation |
| ☐ Poor glycemic control evidenced by 72 hour CGMS sensing trial |
| Has the patient been on a program of multiple daily injections or insulin with frequent self-adjustment of insulin dose for at least 6 months prior to the initiation of the insulin pump? ☐ Yes ☐ No |
| **SUPPORTING CRITERIA (PHYSICIAN TO CHECK ALL THAT APPLY)** |
| ☐ Patient has completed comprehensive diabetes education |
| ☐ Patient has demonstrated ability to self-monitor blood glucose levels as recommended by Physician |
| ☐ Patient is motivated to achieve and maintain improved glycemic control |
| ☐ Patient has been hospitalized or required paramedical treatment for low blood sugar |
| Insulin reaction notes: |
| Additional notes: |

| **PHYSICIAN INFORMATION** | |
|---|---|
| Physician: | NPI #: |
| Hospital/Clinic: | Phone #: |
| Address: | Fax #: |
| City/State/Zip: | Office Contact: |

**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:_____

**PLEASE FAX COMPLETED FORM TO BEDARD PHARMACY & MEDICAL SUPPLIES: 207-795-7622**