AIM PLUS MEDICAL SUPPLIES

Please fax form with Physician's signature to 1-866-496-7054

PATIENT INFORMATION

Name: ______________________________ Date of Birth: ______________________________

Primary Phone: ______________________________ Secondary Phone: ______________________________

Address: ______________________________ City/State/Zip: ______________________________

Primary Insurance: ______________________________ ID# ______________________________

Secondary Insurance: ______________________________ ID# ______________________________

Contact person (if other than patient): ______________________________

REQUIRED INFORMATION FOR ALL PATIENTS

PLEASE COMPLETE THIS SECTION IN FULL

Date of Last Office Visit: ______________ Duration of Need (12 months unless other wise noted): ________

Type 1— IDDM

E10.9 (250.01)

E10.65 (250.03)

Other _______

Type 2—Pills, Diet, and/or Insulin Treated

E11.9 (250.00)

E11.65 (250.02)

Other ________

Using insulin shots to control? ○ YES ○ NO

Number of Injections a day: __________

Currently using a pump? ○ YES ○ NO

Currently on CGM Therapy? ○ YES ○ NO

Testing Frequency: ____________

SMBG per day: ______________

HbA1c: ___________

Fasting Hyperglycemia: _________

Fluctuation of blood glucose values: Low: ________ High: __________

- ☐ Test Strips
  Product Name: ______________
- ☐ Lancets
  Product Name: ______________
- ☐ Lancing Device **PRN**
- ☐ Ketostix
- ☐ Alcohol Wipes
- ☐ Meter Battery **PRN**
- ☐ Control Solution **PRN**
- ☐ Meter **PRN**
- ☐ Transparent Tape
- ☐ Prep Wipes
- ☐ Adhesive Remover
- ☐ Infusion Sets
- ☐ Reservoirs
- ☐ Omnipod Insulin Pump PDM
- ☐ Omnipod Pods
- ☐ Other: ____________________
- ☐ Other: ____________________

CGM Products

- ☐ A9278 Receiver: Dispense 1: DME Only : 1/365 Days
- ☐ A9276 Sensors: Quantity 13 boxes, up to 90 day Supply: DME Only: 365/365 (1 unit = 1 day)
- ☐ A9277 Transmitter Dexcom G6 (3 month use): 4/365 Days
- ☐ A9277 Transmitter Dexcom G5 (3 month use): 4/365 Days
- ☐ A9277 Transmitter Dexcom G4 (6 month use): 2/365 Days

USE PER MANUFACTURER RECOMMENDATIONS

My signature below denotes to the best of my knowledge the patient/ caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items which are designed for home use. The patient/ caregiver has successfully completed training or is scheduled to begin training in the use of supplies or equipment ordered. I am a physician or clinician who manages patients with diabetes, Insulin pump, or CGM therapy and work closely with a team including nurses, diabetes instructors and dieticians who are knowledgeable in the use of subcutaneous insulin infusion therapy.

Physician Staff Contact: ______________________________

Physician Name (print) ______________________________ NPI # ______________________________

Physician Signature ______________________________ **Date** ______________________________

Physician Phone # ______________________________ Fax # ______________________________

SUPPORTING CLINICAL DOCUMENTATION FOR CONTINOUS GLUCOSE MONITORS

- ☐ A. History of hypoglycemia unawareness
- ☐ B. History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity and/or very low insulin requirements
- ☐ C. Recurring episodes of severe hypoglycemia
- ☐ D. Evidence of unexplained severe hypoglycemia episodes requiring external assistance for recovery
- ☐ E. Patient has been hospitalized or has required paramedical treatment for low blood sugar
- ☐ F. 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
- ☐ G. Poor glycemic control as evidenced by 72 hour CGMS sensing trial
- ☐ H. Additionally, patient: has displayed multiple alterations in self-monitoring and insulin regimens to optimize care; completed comprehensive diabetes education; demonstrated ability to self-monitor blood glucose levels as recommended by Physician; and is motivated to achieve and maintain improved glycemic control
- ☐ I. Demonstrates an understanding of technology and are motivated to use the device correctly and consistently, are expected to adhere to comprehensive diabetes treatment plan and are capable of using the device to recognize alerts and alarms

Please be sure that the patient meets the above criteria before sending the attached CMN and documentation to our office.

Thank you!