Diabetic Testing, Insulin Pump and Supplies,

and CGM Detailed Written Order - **Alabama**

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

☐ E10.65

☐ **Other** _____

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

☐ E11.9

☐ E11.65

☐ **Other** _____

HbA1c: _____

Currently using a pump? ☐ YES ☐ **NO**

Currently on CGM Therapy? ☐ **YES** ☐ **NO**

Fasting Hyperglycemia: _____

Testing Frequency: _____

Fluctuation of blood glucose values:

Using insulin shots to control? ☐ **Yes** ☐ **No**

Low: _____ High: _____

Number of injections a day: _____

☐ 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

DEXCOM G6

☐ Receiver: Dispense 1: DME Only : 1/5 years

☐ Sensors: Quantity 13 boxes (units): DME Only: 9 units/90 days

☐ Transmitter Dexcom G6 (3 month use): 4/365 Days

FREESTYLE LIBRE 2

☐ Receiver: Dispense 1: DME Only: 1/5 years

☐ Sensors: Quantity 26.00 units: 6 units/90 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 provider who manages patients with diabetes, insulin pump, or CGM therapy and work closely with a team including nurses, diabetic instructors, and dietitians who are knowledgeable in the use of subcutaneous insulin infusion therapy.

Physician Staff Contact:

_____

Provider Name (print): _____ **Provider NPI #** _____

Provider Phone Number: _____ **Provider Fax:** _____

Provider Signature: _____ **Date:** _____

6521 Hwy 69 S, Ste N, Tuscaloosa, AL 35405 Phone 866-919-1246 Fax 866-496-7054

CLINICAL DOCUMENTATION CHECKLIST FOR AIM PLUS MEDICAL SUPPLIES, LLC

The following must be completed and signed by the physician with supporting documentation.

CONTINUOUS GLUCOSE MONITOR PREREQUISITE CRITERIA- Please check all that apply and include supporting documentation.

☐ Medicaid eligible EPSDT recipients less than 21 years of age and recipients of all ages with Type 1 diabetes and **pregnant**

☐ Patient is diagnosed with Type 1 diabetes mellitus.

☐ Patient has been using a blood glucose monitor (BGM) and performing frequent (four or more per day) testing. Supporting documentation must be submitted.

☐ Patient is insulin-treated with multiple (three or more) daily injections of insulin or a Medicaid-covered continuous subcutaneous insulin infusion (CSII) pump.

☐ Patient's insulin treatment regimen requires frequent adjustment by the patient and/or caregiver based on BGM or CGM testing results.

☐ Within six (6) months before ordering the CGM, the treating practitioner has an in-person visit with the patient to evaluate their diabetes control (to include HbA1c) and determined that criteria (1-4) above are met.

☐ Every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person visit with the patient to assess adherence to their CGM regimen and diabetes treatment plan.

EXTERNAL AMBULATORY INSULIN INFUSION PUMP (E0784) PREREQUISITE CRITERIA

Please check all that apply and include accompanying documentation.

☐ Patient must be Medicaid eligible, less than 21 years of age, and EPSDT eligible.

☐ Patient must have a documented diagnosis of insulin-dependent diabetes mellitus (IDDM, also known as Type 1).

☐ A board-certified endocrinologist must have evaluated the patient and ordered the insulin pump.

☐ Patient must have been on a program of multiple daily injections (MDI) of insulin (i.e., at least three injections per day) for at least six months prior to initiation of the insulin infusion pump. Supporting documentation must be submitted.

☐ Patient has documented frequency of glucose self-testing (i.e., patient "logs") an average of at least four times per day during the three months prior to the insulin pump initiation. The patient must include six consecutive weeks' worth of logs within the three months of the prior authorization request.

☐ Patient and/or caregiver must be capable, physically and intellectually, of operating the pump. Patient/caregiver must demonstrate ability and commitment to comply with the regimen of pump care, diet, exercise, medications, and glucose testing at least four times a day. Supporting documentation must be submitted.

☐ Education on insulin pump must have been conducted before prior authorization request. The patient (caregiver if a child) and educator must sign to document their understanding.

☐ Documentation of active and past recipient compliance with medications, diet, appointments, and other treatment recommendations must be provided.

ADDITIONAL CRITERIA- The patient must also meet one or more of the following, supported by documentation:

☐ Two elevated glycosylated hemoglobin levels (HbA1c>7.0%) within 120 days while on multiple daily injections of insulin.

☐ History of severe glycemic excursions (commonly associated with brittle diabetes, hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity, and/or very low insulin requirements).

☐ Widely fluctuating blood glucose levels before mealtime (i.e., preprandial blood glucose level consistently exceeds 140 mg/dL).

☐ Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL.

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Required supporting documentation from the patient's medical record is attached.

_____ _____

Prescribing Practitioner Signature (Required) **Date**

Stamps/copies of the physician's signature will not be accepted.