Diabetic Testing, Insulin Pump and Supplies,

and CGM Detailed Written Order - **Florida**

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: _____

Fluctuation of blood glucose values:

Low: _____ High: _____

Testing Frequency: _____

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

**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 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:** _____

## DOCUMENTATION

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

**Therapeutic Continuous Glucose Monitors** are **considered medically necessary** when all of the following criteria are met. Please check all that apply and include supporting documentation.

___ 1. The member has diabetes mellitus (type 1DM and type 2DM); **AND,**
___ 2. The member requires twice day BGM (for device calibration for DexCom G5 mobile); **AND,**
___ 3. The member is insulin-treated with multiple daily injections (MDI) of insulin or a continuous subcutaneous insulin infusion (CSII) pump; **AND,**
___ 4. The member's insulin treatment regimen requires frequent adjustment by the member on the basis of therapeutic continuous glucose monitoring (CGM) testing results, **AND,**
___ 5. The member requires insulin injections 3 or more times per day or a medically necessary insulin pump is used for maintenance of blood sugar control.
___ 6. A comprehensive glucose level log is maintained, documenting significant changes in diabetic management as a result of the continuous monitoring

**Pregnant Members- Please check all that apply and send accompanying documentation**

**Continuous (long term)** monitoring of glucose levels in interstitial fluid in **during pregnancy** is **considered medically necessary** if ALL of the below criteria are met.

___ 1. The member has diabetes mellitus; **AND,**
___ 2. The member has been using a home blood glucose monitor (BGM) and performing frequent (four or more times a day) BGM testing; **AND,**
___ 3. The member is insulin-treated with multiple daily injections (MDI) of insulin or a continuous subcutaneous insulin infusion (CSII) pump; **AND,**
___ 4. The member's insulin treatment regimen requires frequent adjustment by the beneficiary on the basis of therapeutic CGM testing results; **AND,**
___ 5. The member has used best practices and was compliant with 4 or more finger sticks per day; **AND,**
___ 6. Continuous glucose monitoring has led to a beneficial series of behavioral modifications resulting in a reduction of hypoglycemic events; **AND,**
___ 7. Insulin injections are required 3 or more times per day or a medically necessary insulin pump is used for maintenance of blood sugar control; **AND,**
___ 8. A comprehensive glucose level log is maintained, documenting significant changes in diabetic management as a result of the continuous monitoring.

External insulin pumps **are considered medically necessary** if the Member:

___ 1. Has a diagnosis of insulin dependent type I diabetes mellitus; **AND**
___ 2. Completed a comprehensive diabetes education program. (This may include, but is not limited to, leading the Member to demonstrate the ability and commitment to comply with the regimen of pump care, frequent self-monitoring of blood glucose, and careful attention to diet and exercise, and has received appropriate training on pump usage); **AND**
___ 3. Has been on a program of multiple daily injections of insulin (e.g., at least 3 injections per day) with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump; **AND**
___ 4. Member has been on an external insulin infusion pump prior and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to enrollment; **AND**
___ 5. Has an endocrinologist or physician experienced in providing insulin infusion therapy orders the insulin pump and states that he/she will monitor the members status while he/she uses the pump; **AND**
___ 6. Has Provider documentation of a history of poor glycemic control on multiple daily injections of insulin, including a persistently elevated glycosylated hemoglobin level (HBA1C>7.0%). Additional history of poor control may be documented in the medical record, including but not limited to:

- ___ Widely fluctuating blood glucose levels before bedtime **OR**
- ___ History of severe hypoglycemia (<60mg/dL) or hyperglycemia (>300 mg/dL) **AND/OR**
- ___ Treatment of secondary diabetic complications requiring more extensive blood glucose control

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by Staywell/Wellcare Florida Medicaid. 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