Diabetic Testing, Insulin Pump and Supplies, CGMs
Detailed Written Order – Medicaid/Commercial

AIM PLUS MEDICAL SUPPLIES

Please Fax Form with Physician's Signature to
1-866-496-7054 AIM Plus Medical Supplies

PATIENT INFORMATION

Name: _____ Date of Birth: _____

Primary Phone: _____ Secondary Phone: _____

Address: _____ City/State/Zip: _____

Primary Insurance: _____ ID# _____

Contact Person (if other than patient): _____

REQUIRED INFORMATION FOR ALL PATIENTS
PLEASE FULLY COMPLETE THIS SECTION

Date of Last Office Visit: _____

Duration of Need (12 mo. Unless Otherwise Noted): _____

Type 1 - IDDM	Type 2- Pills, Diet, and/or Insulin Treated
☐ E 10.9	☐ E 11.9
☐ E 10.65	☐ E 11.65
☐ E 10.649	☐ Other _____

HbA1c: _____

Currently Using a Pump? ☐ Yes ☐ No

Currently on CGM Therapy? ☐ Yes ☐ No

Fasting Hyperglycemia: _____

Testing Frequency: _____ X Per Day

Fluctuation of Blood Glucose Values:

Using Insulin Injections to Control? ☐ Yes ☐ No

Low: _____ High: _____

Number of Injections: _____ X Per Day

PRODUCTS- USE PER MANUFACTURERS RECOMMENDATION

☐ Testing Supplies: Glucometer, test strips, lancing device, lancets, ketone strips, control solution, alcohol wipes- PRN

☐ CGM, Dexcom G6: Sensors, transmitter, receiver, prep wipes, adhesive remover, dressing- PRN

☐ CGM, Dexcom G7: Sensors (transmitter included), receiver, prep wipes, adhesive remover, dressing- PRN

☐ CGM, FreeStyle Libre 2: Sensors, Reader, prep wipes, adhesive remover, dressing- PRN

☐ Insulin Pump: ☐ Tandem T-slim Control IQ ☐ Tandem T-slim Basal IQ

☐ Medtronic MiniMed 630G ☐ Medtronic MiniMed 770G

☐ Insulin Pump Supplies: Reservoirs, infusion sets, prep wipes, adhesive remover, dressing- PRN

☐ Omnipod 5 Starter Kit ☐ Omnipod 5 Supplies: Pods (5 per box), prep wipes, adhesive remover, dressing – PRN

☐ Other: _____

*Items may be substituted as appropriate.

**My signature below denotes to the best of my knowledge the patient/caregiver can 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 dieticians who are knowledgeable in the use of subcutaneous insulin infusion therapy.

PLEASE PRINT NAME, SIGN, AND DATE

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

The following must be completed and signed by the treating practitioner 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 old and for all ages who are Type 1 diabetics and pregnant.
- ☐ Patient is diagnosed with Type 1 diabetes mellitus; **and**
- ☐ Patient is insulin-treated with multiple (three or more) daily injections of insulin, or a Medicaid covered continuous subcutaneous insulin infusion (CSII) pump; **and**
- ☐ Patient's insulin treatment regimen requires frequent adjustment by the patient and/or caregiver on the basis of BGM or CGM testing results; **and**
- ☐ Within 6 months prior to ordering the CGM, the treating practitioner has an in-person visit with the patient to evaluate their diabetes control (to include HbA1c) and determine that the above criteria are met; **and**
- ☐ Every 6 months following the initial prescription of the CGM, the treating practitioner has an in-person visit with the beneficiary 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/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.
- ☐ Patient has a documented frequency of glucose self-testing (i.e. patient "logs") an average of at least four times per day during the three-month period prior to initiation of the insulin pump. Patient must include six consecutive weeks' worth of logs within the three months prior to 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.
- ☐ Education on insulin pump MUST have been conducted prior to the prior authorization request, and the patient, caregiver if child, and educator must sign to demonstrate understanding.
- ☐ Documentation of active and past recipient compliance with medications and diet, appointments, and other treatment recommendations must be provided.

ADDITIONAL CRITERIA FOR INSULIN PUMPS: The patient must meet **one or more** of the following:

- ☐ Two elevated glycosylated hemoglobin levels (Hb**A**1c>7.0%) within a 120-day time span, while on multiple 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., pre-prandial blood glucose level consistently exceeds 140mg/dL).
- ☐ Dawn phenomenon with fasting blood sugar levels frequently exceeding 200mg/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 practitioner's signature will not be accepted.