

AIM PLUS MEDICAL SUPPLIES

Diabetic Testing, CGM, Insulin Pump, and Supplies - Detailed Written Order/Standard Written Order

Medicaid/Commercial

Please Fax Form with Provider's Signature to 1-866-496-7054

PATIENT INFORMATION

Name: _____ Date of Birth: _____
Primary Phone: _____ Secondary Phone: _____
Primary Address: _____
City/State/Zip: _____
Primary Insurance: _____ Insurance ID#: _____
Email: _____
Contact Person: _____

REQUIRED INFORMATION FOR ALL PATIENTS - Please Fully Complete This Section

Date of Last Office Visit: _____ Duration of Need: _____ Mo. (12 unless noted)

Type 1-IDDM:

E10.9 E10.65 E10.649 Other: _____

Type 2-Pills, Diet, and/or Insulin Treated:

E11.9 E11.65 Other: _____

Testing Frequency: _____ x per Day Using Insulin: Yes No

Number of insulin treatments: _____ X Per Day Using a Pump?: Yes No

A1c: _____ Currently on CGM Therapy?: Yes No

Fasting Hyperglycemia: _____

Fluctuation of Blood Glucose Values: Low _____ High _____

RECOMMENDED PRODUCTS (PRN - Use Per Manufacturers)

- Testing Supplies:** Glucometer, test strips, lancets, lancing device, control solution, ketone strips, alcohol wipes
- CGM, Dexcom G6:** Sensors, transmitter, receiver, prep wipes, adhesive remover, dressing
- CGM, Dexcom G7:** Sensors (transmitter included), receiver, prep wipes, adhesive remover, dressing
- Freestyle Libre 2 Plus:** Sensors, reader, prep wipes, adhesive remover, dressing
- Freestyle Libre 3 Plus:** Sensors, reader, prep wipes, adhesive remover, dressing
- Insulin Pump Supplies:** Infusion sets, reservoirs, prep wipes, adhesive remover, dressing
- Tandem Control IQ Insulin Pump** **Tandem Mobi Insulin Pump** **Beta Bionics iLet Insulin Pump**
- Omnipod 5 Starter Kit**
- Omnipod 5 Pods:** Pod (5 per box), prep wipes, adhesive remover, dressing
- Omnipod Dash Pods:** prep wipes, adhesive remover, dressing
- Other:** _____

PROVIDER ATTESTATION

My signature below denotes, to the best of my knowledge, that the patient or parent/caregiver can follow instructions for managing diabetes and is able to use the ordered items, which are designed for home use, including hearing and/or viewing alerts and responding as needed. The patient or parent/caregiver has completed training or is scheduled to begin training in using supplies or equipment ordered. I am a provider who manages patients with diabetes, insulin pump, or CGM therapy and works closely with a team including nurses, diabetic educators/instructors, and dietitians knowledgeable in the use of subcutaneous insulin infusion therapy. For CGM and insulin pump renewals, the patient listed on this DWO/SWO is under my care and followed by my clinic. I am writing in support of the continued use and coverage of the prescribed device(s) and supplies. The device(s) remain medically necessary for this patient to have optimal blood glucose control.

PROVIDER INFORMATION

Provider Name (Print): _____ Provider NPI: _____
Provider Phone: _____ Provider Fax: _____
Provider Signature: _____ Date: _____

Alabama Medicaid Agency Continuous Glucose Monitoring

INITIAL DETERMINATION CRITERIA: CGM will require prior authorization (PA), and is considered medically appropriate under the following circumstances:

- Recipient is diagnosed with type 1 diabetes mellitus
OR
- Recipient is diagnosed with type 2 diabetes mellitus **AND** is insulin-treated with multiple (three or more) daily injections of insulin
AND
- The prescribing practitioner must evaluate the patient within six months prior to ordering the CGM, and at least every six months thereafter, to assess diabetes control, determine medical necessity, and confirm the criteria above are met.

*All requests **must** have supporting documentation. Documentation may include notes from the patient chart and/or pharmacy printouts.*

RECERTIFICATION/RENEWAL:

For patients who have received CGM equipment and supplies through Alabama Medicaid and need a PA renewal, an updated prescription from the prescriber as well as the initial determination criteria above must be met.

Note: Coverage for non-medical items, even when the items may be used to serve a medical purpose, such as smart devices (smart phones, tablets, personal computers, etc.) are non-covered. This includes smart devices used in conjunction with CGMs.

*Alabama Medicaid does not prefer one brand of CGM over the other. PAs for supplies will be approved for up to 1 year **OR** the expiration of the written order/prescription (whichever comes first).*

PROCEDURE CODES

A4239 and E2103

All procedure codes require PA.

Criteria Checklist
MUST ACCOMPANY THE PRIOR AUTHORIZATION FORM

Alabama Medicaid Agency
External Ambulatory Insulin Infusion Pump (E0784)

Children under 21 years of age and EPSDT eligible

PREREQUISITE CRITERIA *The patient must meet all of the following:*

- 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 I).
- 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 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 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 prior to prior authorization request, and each the patient, caregiver if child, and educator signed to document* their understanding.
- Documentation* of active and past recipient compliance with medications and 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 a 120-day time span, 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., pre-prandial blood glucose level consistently exceeds 140 mg/dL).
- Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL.

RECERTIFICATION/RENEWAL:

For patients who have received external ambulatory insulin infusion pump equipment and supplies through Alabama Medicaid and are in need of a Prior Authorization Renewal, an updated prescription and an attestation from the patient’s prescribing provider, stating their recommendation for continued use of the insulin delivery system/pump and pods, is required.

DIAGNOSIS CODES

Approval will be given for only type I diabetes mellitus diagnosis codes. Please refer to Chapter 14 of the Provider Manual for the ICD-10 crosswalk codes.

PROCEDURE CODES

E0784, A4221, A4232, A4230, A9274

Maximum yearly limits apply to each of the procedure codes indicated above. Requests for replacement of E0784 will be limited to once every five years based on a review of submitted documentation requested.

**Documentation may include notes from the patient chart and/or pharmacy printouts (to support medication compliance history).*

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)
(Stamps/copies of physician’s signature will not be accepted)

Date