

**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: \_\_\_\_\_

