HLMS HEALTHY LIVING MEDICAL SUPPLY

Insulin Pump Prescription
2111 Woodward Ave., Suite 1100, Detroit, MI 48201
Phone: 866.779.8512 | Fax: 866.779.8511 | myhlms.com

Patient Information ***Order/Start Date:___/___/___***

Name:	Date of Birth:	Sex: ___ Male ___ Female
Address:		City:
State:	Zip:	Phone:

Insurance

Primary Insurance:	Secondary Insurance:
Policy ID:	Policy ID:

Physician Information

Physician Name:	NPI:
Phone:	Fax:
If signed by someone other than physician above, print name:	

1. Diagnosis Code: *(Please check diagnosis code and if patient is insulin-treated.)*
Type 1 = [ ] E10.9 (no complications) [ ] E10.___ - list additional digits
Type 2 = [ ] E11.9 (no complications) [ ] E11.___ - list additional digits
Is patient treated with insulin? ___Yes ___ No Is patient on an insulin pump? ___Yes ___ No
If not on an insulin pump, how many insulin injections/day in last 6 months: _____ HbA1c Result: _____ Date: _____

2. Duration of Need:
Lifetime: _____
Other: _____
(*Lifetime equals 12 months for non-Medicare. If no duration is specified, prescription defaults to Lifetime.)

3. Testing Frequency: _____ times/day
Monthly Supply: (Strips/Lancets)
- 1x day, 50/100
- 2-3x day, 100/100
- 4-5x day, 150/200
- 6 or more x day, 200/200

4. Utilization Guidelines
Has patient been seen in last 6 months? ___Yes ___No
I have documented in the patient's medical record the times testing, and the reason for high testing frequency is:
__ Fluctuating blood sugar __Hypoglycemia __Hyperglycemia
__ Uncontrolled blood sugar __Hypertension __Other:

5. Testing Supplies
Please **CIRCLE ALL** that are needed:
- Glucose meter (1)
- Test strips
- Lancets
- Lancing device (1/6 months)
- Control solution (1/3 months)
- Alcohol swabs (100/box)
- Ketone strips (100/box)
- Meter batteries (1/order)

6. Insulin Pump & Supplies
Please **CIRCLE ALL** that are needed:
Insulin pump (1), **Type: _____**
Reservoirs (30/order)
Infusion sets/tubing (30/order)
Change site every _____ days
IV Prep wipes (100/order)
Adhesive remover wipes (50/order)
Transparent Dressing (100/order)
Skin prep wipes (50/order)
Insertion device (1)
Pump batters (3/order)
Continuous Glucose Monitoring System:
Sensors (10/order)
Transmitter (1/6 months)
Receiver (1/12 months)
Other: _____

Please send all faxes to 866.779.8511.
Thank you!

7. Medical Criteria for Insulin Pump
Certifying statement, complications, and additional criteria:
___ I certify that my patient has completed a comprehensive diabetes education program, has been on a program of multiple daily insulin injections with frequent self-adjustment for at least 6 months and has documented frequency of blood glucose self-testing an average of at least 4 times per day for the past 2 months and meets at least one of the following complications:

(CIRCLE OR CHECK ALL THAT APPLY)
___ HbA1c Level >7.0%
___ History of recurring hypoglycemia
___ Wide fluctuations in blood glucose before mealtime
___ Dawn phenomenon with fasting blood glucose exceeding 200 mg/dl
___ History of severe glycemic excursions
___ OR This is a replacement pump
REASON: _____

Additional Complications:

___ #1 C-peptide testing requirement must meet one of the following:
◯ C-Peptide level is ≤110% of the laboratory's lower limit of normal
- OR-
◯ Renal insufficiency and a creatinine less than or equal to 50 ml/minute, a fasting C-peptide level 200% of the laboratory's lower limit of normal

Must meet the following requirement if #1 is checked:
◯ A fasting blood glucose of 225 mg/dl obtained at the same time as C-peptide level

___ #2 Beta cell autoantibody test is positive

By signing below, I confirm that the patient has diabetes and is being treated by me. All the information contained on this form accurately reflects the patient's diabetic condition and the treatment regimen I have prescribed. The medical records for this patient substantiate the prescribed testing frequency. The patient/caregiver is able to follow instructions for controlling diabetes and is able to use the ordered items. For Medicare/Insurance requirements, I will maintain this signed original document in the patient's medical record file for post-payment review/audit purposes.

Signature: _____ Date: _____