

**Letter of Medical Necessity
 /Prescription**

Patient _____ Phone () _____

Address _____ City _____ State _____ Zip _____

Date of Birth _____ Social Security _____ Patient ID _____

Diagnosis Codes: _____ 250.01 _____ 250.9 _____ Other _____

This letter serves as a lifetime Prescription and Letter of Medical Necessity for the above referenced patient for the following insulin infusion pump and all related supplies.

UPGRADE NEW PUMP

Insulin Pump

- MiniMed 722 Blue Smoke Clear Purple
- MiniMed 522 Blue Smoke Clear Purple
- Deltec Cozmo Blue Green Black
- Animas 2020 Blue Silver Black
- Roche Accu-Chek Spirit
- _____

Supplies

- IV 3000
- Skin Preps
- _____
- _____
- _____
- _____

CHECK THE FOLLOWING:

- ___ Patient has had diabetes for _____ years.
- ___ Patient has the ability to regularly monitor blood glucose ___ to ___ times per day.
- ___ Patient is motivated to achieve glycemic control & has the support to stay motivated.
- ___ Patient demonstrates compliance with dietary regimen.
- ___ Patient displays the social, physical and intellectual skills to be successful at insulin pump therapy.
- ___ Patient's insulin regimen consists of _____ to _____ injections per day.
- ___ Patient uses the following types of insulin: _____.
- ___ Patient has demonstrated the ability to intense insulin management.

PATIENT EXHIBITS ONE OR MORE OF THE FOLLOWING:

- ___ Glycosolated Hemoglobin A1C _____% on _____ / _____ / _____.
- ___ History of severe glycemic excursions and/or ___ Nocturnal Hypoglycemia
- ___ Hypoglycemia unawareness ___ Extreme insulin sensitivity or low insulin requirements.
- ___ Widely fluctuating glucose levels before meals (e.g. pre-prandial BG levels commonly exceeds 140 mg/dl and/or below 70 mg/dl. The range of BG levels is from ___ to ___.
- ___ Dawn phenomenon where fasting blood glucose level often exceeds _____.
- ___ Pregnancy or preconception with a history of poor glycemic control.
- ___ Retinopathy, neuropathy, and/or nephropathy.
- ___ Patient has been hospitalized or needed emergency assistance due to his/her diabetes.

REMARKS: _____

I certify that this information is complete and correct.

Physician's Signature

Physician's UPIN#

Physician's Printed Name

Physician's DEA#