

Certificate of Medical Necessity (CMN) for Insulin Pump – Medicare Advantage

Date: ____/____/____ Requesting Provider: _____

Pt. Name: _____ I.D. Number: _____

1. Enter laboratory values (performed at the same blood draw):

Fasting C-peptide level _____

Fasting blood sugar _____ (mg/dl)

Actual or calculated creatinine clearance _____ (ml/minute)

Laboratories lower limit of normal for fasting C-peptide level _____

2. Did your patient have a Positive Beta Autoantibody Test? Y N

3. Has your patient completed a comprehensive diabetes education program, been on a program of multiple daily injections (at least 3 injections per day) with frequent self adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump, and has documented frequency of glucose self testing an average of at least 4 times per day during the 2 months prior to the initiation of the insulin pump, **and** meets one or more of the following criteria? Y N

(CIRCLE ALL THAT APPLY):

- a. Glycosylated hemoglobin level (HgbA1c) greater than 7%
- b. History of recurring hypoglycemia
- c. Wide fluctuation in blood glucose before mealtime
- d. Dawn phenomenon - fasting blood sugars frequently exceeding 200 mg/dL
- e. History of severe glycemic excursions

4. Has your patient been on an external insulin infusion pump prior to enrollment in Medicare and have they documented glucose self testing an average of at least 4 times per day during the month prior to Medicare enrollment? Y N

Additional Clinical Rationale (Print):

Contact Name: _____ Phone : _____

Physician Signature (Stamps are not acceptable) Date

Key - (Y)es, (N)o, (D)oes not apply

Requested Information:

- 1. Typed office note with pertinent information.
- 2. Copy of Laboratory Tests