

Precertification for Medical Necessity External Insulin Infusion Pump

***Please submit this form completed and signed by
prescribing physician. Include record of self-
monitoring of blood glucose documentation for one
month and physician notes for the last two visits***

Date of request: _____ Subscriber's ID #: _____

Patient's Name: _____ DOB: _____

Patient's Address: _____ Patient's Daytime Phone: _____

_____ Patient's Evening Phone: _____

Physician who will manage pump: _____ Specialty: _____

Type of insulin pump prescribed: _____ Date of start-up pump training: _____

Date of Diabetes Diagnosis: _____ Diabetes: Type 1 Type 2 Date insulin initiated: _____

Most recent Hemoglobin A1c (must be within last six months): _____ Self monitors blood glucose: _____ X a day

Date of Carbohydrate Counting Instruction: _____ (Required for pump consideration)

Current diabetes medications, include dosage and frequency (for insulin therapy indicate date that current therapy was initiated).

Please check all diabetic complications that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Widely fluctuating blood glucose levels | <input type="checkbox"/> Dawn phenomenon | <input type="checkbox"/> Hypoglycemia unawareness |
| <input type="checkbox"/> Persistent hyperglycemia | <input type="checkbox"/> Retinopathy | <input type="checkbox"/> Post renal transplant |
| <input type="checkbox"/> DKA | <input type="checkbox"/> Nephropathy | <input type="checkbox"/> Pregnant or planning pregnancy within ____ months |
| <input type="checkbox"/> Frequent hypoglycemia | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Other _____ |

Physician's Certification of Personal Indicators

- | | | |
|------------------------------|-----------------------------|--|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Demonstrates compliance with current diabetes regimen |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Desires better glycemic control |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Physically and psychologically capable (or has capable care partner) |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Understands and uses carbohydrate counting |

Fax this completed form to:
BlueChoice HealthPlan
800-610-5685

Physician's Name (Please Print)

Physician's Signature



Instructions for Requesting an External Insulin Infusion Pump

Fax the following items to the fax number below:

- ***Precertification of Medical Necessity - External Insulin Infusion Pump***
 - This form must be completed by the physician (or designated staff) who will actually be managing the insulin pump.
 - The managing physician must sign the form.
 - **All** sections of the form must be completed.
- Copies of physician notes for the last two office visits.
- Documentation of the result of the last Hemoglobin A1c test. This test must be within the last six months.
- Record of the last month's blood glucose monitoring (either meter download or written records).
- Completed ***Request for Preauthorization of Benefits for Ancillary Services***. This form may be found on our Web site at www.bluechoicesc.com.

Fax the completed forms to:

**BlueChoice HealthPlan
800-610-5685**

If you have questions about this form, call the Great Expectations® for health Diabetes program at 800-327-3183, extension 25224 or e-mail beth.parris@bluechoicesc.com