

Name of provider _____
 Provider NPI # _____
 Medicaid Legacy # _____

Ohio Department of Medicaid
CERTIFICATE OF MEDICAL NECESSITY/PRESCRIPTION
EXTERNAL INSULIN INFUSION PUMP

INITIAL Prescription Date: _____ RECERTIFICATION _____ PA#: _____ REVISED _____ PA#: _____

Instructions: The Certificate of Medical Necessity (CMN) must be used for all External Insulin Infusion Pumps under the Ohio Medicaid Program. This form must be completed and carry the proper signature, where indicated, before requests will be considered for prior authorization.

Name of consumer	Consumer sex <input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth
Consumer Ht (in)/ WT (lbs)		

Service requested <input type="checkbox"/> 3 month trial rental Dates _____ to _____	<input type="checkbox"/> Additional months of rental _____ <input type="checkbox"/> Purchase
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Section A - Must be completed by prescriber

Pertinent diagnosis(es): Include ICD-9 code and description	C-peptide level
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<input type="checkbox"/> Y <input type="checkbox"/> N	Consumer has Type I Diabetes
<input type="checkbox"/> Y <input type="checkbox"/> N	The consumer has completed a diabetes education program within the last 24 months of being prescribed an insulin infusion pump
<input type="checkbox"/> Y <input type="checkbox"/> N	The consumer has been on a program of multiple daily injections of insulin, with frequent self-adjustments of insulin dose, for at least 6 months before initiation of the insulin infusion pump
<input type="checkbox"/> Y <input type="checkbox"/> N	The consumer had documented frequency that is kept in the consumer's medical record of glucose self-testing an average of at least 4 times per day during the 2 months before initiation of the insulin infusion pump
<input type="checkbox"/> Y <input type="checkbox"/> N	The consumer is at high risk for preventable complications of diabetes

<input type="checkbox"/> Y <input type="checkbox"/> N Consumer's glycosylated hemoglobin level (HbA1c) is greater than 7%	<input type="checkbox"/> Y <input type="checkbox"/> N Consumer's dawn phenomenon with fasting blood sugars frequently exceeds 200 mg/dL
<input type="checkbox"/> Y <input type="checkbox"/> N Consumer has a history of recurring hypoglycemia	<input type="checkbox"/> Y <input type="checkbox"/> N Consumer has a history of severe glycemic excursions
<input type="checkbox"/> Y <input type="checkbox"/> N Consumer has wide fluctuations in blood glucose before mealtime	

Explain all "No" responses

Reason external insulin infusion pump is being ordered

Section B - Documentation of compliance (complete after trial period) Must be completed by prescriber

<input type="checkbox"/> Purchase after 3 month trial rental <input type="checkbox"/> Y <input type="checkbox"/> N Consumer is compliant in the use of the pump <input type="checkbox"/> Y <input type="checkbox"/> N Consumer is able to manage pump	<input type="checkbox"/> Y <input type="checkbox"/> N There is a desired improvement in metabolic control <input type="checkbox"/> Y <input type="checkbox"/> N Consumer has received a 1 year product warranty for the pump (one year from date of purchase)
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Section C - Prescriber Attestation and Signature/Date (Signed/dated no more than 30 days before the first date of service)

Prescriber's name (Printed) and Phone Number to include Area Code

I certify that I am the prescriber identified above. I certify that the information I have completed in this certificate is of medical necessity and any information on any attached documents signed and dated by me is true to the best of my knowledge. I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Prescriber's signature (No stamps)	Date	Prescriber's NPI and Medicaid Legacy Number
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