Name of provider:_____

Provider NPI # _____

Medicaid Legacy # _____

Ohio Department of Job and Family Services

Certificate of Medical Necessity/Prescription

External Insulin Infusion Pump

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 recipient:	Billing Number:	Date of Birth

Service requested:

☐ **3 month trial rental**

Dates: ___/___/____ to ___/___/____

☐ **Additional months of rental _____**

☐ **Purchase**

Section A—Must be completed by physician

Pertinent diagnosis(es): Include ICD-9 code and description	C-peptide level

Y N Consumer has Type I Diabetes

Y N The consumer has completed a diabetes education program within the last 24 months of being prescribed an insulin infusion pump

Y 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.

Y 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.

Y N The consumer is at high risk for preventable complications of diabetes

Y N Consumer's glycated hemoglobin level (HbA1c) is greater than 7%

Y N Consumer has a history of recurring hypoglycemia

Y N Consumer has wide fluctuations in blood glucose before mealtime

Y N Consumer's dawn phenomenon with fasting blood sugars frequently exceeds 200 mg/dL;

Y N Consumer has a history of severe glycemic excursions

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 physician

☐ **Purchase after 3 month trial rental**

Y N Consumer is compliant in the use of the pump

Y N Consumer is able to manage pump

Y N There is a desired improvement in metabolic control

Y N Consumer has received a 1 year product warranty for the pump (one year from date of purchase)

Section C—Physician Attestation and Signature/Date (Signed/dated no more than 30 days before the first date of service)

Physician's name (PRINTED)

I certify that I am the physician 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.

Physician signature: (No stamps)	Date: ____/____/____	Ohio Medicaid Provider #: