Diabetic Testing, CGM, Insulin Pump, and Supplies
Detailed Written Order- Medicaid/Commercial

Please Fax Form with Provider's Signature to
AIM Plus Medical Supplies 1-866-496-7054

PATIENT INFORMATION

Name: _____ **Date of Birth**_____

Primary Phone: _____ **Secondary Phone:** _____

Address: _____ **City/State/Zip:** _____

Primary Insurance: _____ **ID#** _____

Contact Person: _____ **Email:** _____

REQUIRED INFORMATION FOR ALL PATIENTS - PLEASE FULLY COMPLETE THIS SECTION

Date of Last Office Visit: _____ **Duration of Need:** _____ **mo. (12 unless noted)**

Type 1 -IDDM ☐ **E 10.9** ☐ **E 10.65** ☐ **E 10.649** ☐ **Other:** _____

Type 2- Pills, Diet, and/or Insulin Treated ☐ **E 11.9** ☐ **E 11.65** ☐ **Other:** _____

Testing Frequency: _____ **X per Day** **Using Insulin treatment to control?** ☐ **Yes** ☐ **No**

Number of insulin treatments: _____ **X Per Day** **A1c:** _____ **Currently Using a Pump?** ☐ **Yes** ☐ **No**

Currently on CGM Therapy? ☐ **Yes** ☐ **No** **Fasting Hyperglycemia:** _____

Fluctuation of Blood Glucose Values: _____ **Low** _____ **High**

PRODUCTS PRN- USE PER MANUFACTURERS RECOMMENDATION

☐ **Testing Supplies: Glucometer, test strips, lancing device, lancets, ketone strips, control solution, alcohol wipes**

☐ **CGM, Dexcom G6: Sensors, transmitter, receiver, prep wipes, adhesive remover, dressing**

☐ **CGM, Dexcom G7: Sensors (transmitter included), receiver, prep wipes, adhesive remover, dressing**

☐ **FreeStyle Libre 2 or** ☐ **FreeStyle Libre 3 or** ☐ **FreeStyle Libre 2+: Sensors, reader, prep wipes, adhesive remover, dressing**

☐ **Insulin Pump Supplies: Reservoirs, infusion sets, prep wipes, adhesive remover, dressing**

☐ **Tandem Control IQ Insulin Pump** ☐ **Tandem Mobi Insulin Pump** ☐ **Beta Bionics iLet Insulin**

☐ **Omnipod 5 Starter Kit** ☐ **Omnipod 5 Pods: Pod (5 per box), prep wipes, adhesive remover, dressing**

☐ **Omnipod Dash Supplies: Pods, prep wipes, adhesive remover, dressing**

☐ **Other:** _____

****My signature below denotes, to the best of my knowledge, the parent/caregiver can follow instructions for controlling diabetes and is able to use the ordered items, which are designed for home use, including being able to hear and/or view alerts and respond as needed. The parent/caregiver has successfully completed training or is scheduled to begin training in using supplies or equipment ordered. I am a provider who manages patients with diabetes, insulin pump, or CGM therapy and works closely with a team including nurses, diabetic instructors, and dietitians knowledgeable in the use of subcutaneous insulin infusion therapy. For CGM and insulin pump renewals, the patient listed on this CMN is under my care and is followed by our clinic. I am writing to support the continued use and coverage of the prescribed device(s) and supplies. The device(s) remain medically necessary for this patient to have optimal blood glucose control.**

Provider Name (Print): _____ **Provider NPI:** _____

Provider Phone Number: _____ **Provider Fax:** _____

Provider Signature: _____ **Date:** _____

Criteria Checklist

Alabama Medicaid Agency
Continuous Glucose Monitoring

PREREQUISITE CRITERIA *All of the following **must** be met with supporting documentation*:*

- ☐ Patient is a child diagnosed with Type 1 diabetes mellitus or pregnant female (Type 1 or 2); and
- ☐ Patient is insulin-treated with multiple (three or more) daily injections of insulin or a Medicaid-covered continuous subcutaneous insulin infusion (CSII) pump.
- ☐ Patient's insulin treatment regimen requires frequent adjustment by the patient and/or caregiver on the basis of BGM or CGM testing results.
- ☐ Within six (6) months prior to ordering the CGM, the treating practitioner has an in-person visit with the patient to evaluate their diabetes control (to include HbA1c) and determined that criteria (1-4) above are met.
- ☐ Every six (6) months following the initial prescription of the CGM, the treating practitioner has an in-person visit with the patient to assess adherence to their CGM regimen and diabetes treatment plan.

RECERTIFICATION/RENEWAL:

For patients who have received CGM equipment and supplies through Alabama Medicaid and are in need of a Prior Authorization Renewal, an updated prescription and an attestation from the patient's prescribing provider, stating their recommendation for continued CGM therapy, is required. A request for replacement of the External Receiver will be considered for approval every five years upon review of submitted medical documentation. If a replacement request is submitted within less than five years and the replacement is due to a natural disaster and not the result of misuse, neglect or malicious acts by the user, the request may be considered for approval and payment.

Limitations

Approval will be given for only type I diabetes mellitus diagnosis codes. Please refer to Chapter 14 of Provider Manual for the ICD-10 crosswalk codes.

PROCEDURE CODES

A9276, A9277, and A9278
A4239 and E2103

Effective November 1, 2023, the DME Program will make changes to the CGM Billing Procedures and CGM Prior Authorization requests. For NEW prior authorization requests submitted on or after November 1, 2023, providers must bill and submit on the prior authorization CGM procedure codes A4239 and E2103 for non-adjunctive CGM models. Existing prior authorizations approved for A9276, A9277, and A9278 prior to November 1, 2023, will remain active and providers will be allowed to bill remaining units on existing prior authorizations through October 31, 2024. Procedure codes A9276, A9277, and A9278 will be non-covered on November 1, 2024.

Maximum limits apply to each of the procedure codes indicated above. CGM devices are limited to one every five years, require prior authorization and will be considered based upon the review of submitted documentation.

Criteria Checklist
MUST ACCOMPANY THE PRIOR AUTHORIZATION FORM

Alabama Medicaid Agency
External Ambulatory Insulin Infusion Pump (E0784)

Children under 21 years of age and EPSDT eligible

PREREQUISITE CRITERIA *The patient **must** meet all of the following:*

- ☐ Patient must be Medicaid eligible, less than 21 years of age, and EPSDT eligible.
- ☐ Patient must have a documented* diagnosis of insulin dependent diabetes mellitus (IDDM, also known as type I).
- ☐ A board certified endocrinologist must have evaluated the patient and ordered the insulin pump.
- ☐ Patient must have been on a program of multiple daily injections (MDI) of insulin (i.e., at least three injections per day) for at least six months prior to initiation of the insulin infusion pump. Supporting documentation* must be submitted.
- ☐ Patient has documented frequency of glucose self-testing (i.e. patient "logs") an average of at least four times per day during the three months prior to initiation of the insulin pump. Patient must include six consecutive weeks' worth of logs within the three months prior to the prior authorization request.
- ☐ Patient and/or caregiver must be capable, physically and intellectually, of operating the pump. Patient/caregiver must demonstrate ability and commitment to comply with regimen of pump care, diet, exercise, medications, and glucose testing at least four times a day. Supporting documentation* must be submitted.
- ☐ Education on insulin pump MUST have been conducted prior to prior authorization request, and each the patient, caregiver if child, and educator signed to document* their understanding.
- ☐ Documentation* of active and past recipient compliance with medications and diet, appointments, and other treatment recommendations must be provided.

ADDITIONAL CRITERIA *The patient **must also** meet **one or more** of the following, supported by documentation**:*

- ☐ Two elevated glycosylated hemoglobin levels (HbA1c> 7.0%) within a 120-day time span, while on multiple daily injections of insulin.
- ☐ History of severe glycemic excursions (commonly associated with brittle diabetes, hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity and/or very low insulin requirements).
- ☐ Widely fluctuating blood glucose levels before mealtime (i.e., pre-prandial blood glucose level consistently exceeds 140 mg/dL).
- ☐ Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL.

RECERTIFICATION/RENEWAL:

For patients who have received external ambulatory insulin infusion pump equipment and supplies through Alabama Medicaid and are in need of a Prior Authorization Renewal, an updated prescription and an attestation from the patient's prescribing provider, stating their recommendation for continued use of the insulin delivery system/pump and pods, is required.

DIAGNOSIS CODES

Approval will be given for only type I diabetes mellitus diagnosis codes. Please refer to Chapter 14 of the Provider Manual for the ICD-10 crosswalk codes.

PROCEDURE CODES

E0784, A4221, A4232, A4230, A9274

Maximum yearly limits apply to each of the procedure codes indicated above. Requests for replacement of E0784 will be limited to once every five years based on a review of submitted documentation requested.

**Documentation may include notes from the patient chart and/or pharmacy printouts (to support medication compliance history).*

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Required supporting documentation from the patient's medical record is attached.

_____

Prescribing Practitioner Signature (Required) Date
(Stamps/copies of physician's signature will not be accepted)