STATEMENT OF MEDICAL NECESSITY

Patient Name: ______________________ DOB: ___/___/___
Health Plan: MMM of Florida ______________ Member #: ______________

Please fax below form to (305) 571-6276. Send this order form along with A1C labs, progress notes, and a complete prescription.

Diagnosis (ICD-10 code):
- ☐ E10.65 Type 1 diabetes mellitus with hyperglycemia
- ☐ E11.65 Type 2 diabetes mellitus with hyperglycemia
- ☐ E11.8 Type 2 diabetes mellitus with unspecified complications
- ☐ E10.9 Type 1 diabetes mellitus without complications
- ☐ E11.9 Type 2 diabetes mellitus without complications
- ☐ Z79.4 Long term (current) use of insulin

Length of Need: ______________

Glucose Monitor & Supplies

☐ E0607 Blood Glucose Monitor	True Metrix Meter Kit NDC: 56151-1470-02 ***Max quantity is 1 meter/year. Greater quantities would require prior authorization.***
☐ A4253 Test Strips	True Metrix Test Strips (50ct) NDC: 56151-1463-04 **Frequency of Use:** ☐ Daily ☐ 2 times daily ☐ 3 times daily ☐ More than 3 times a day ***Max quantity for member utilizing insulin is 100 strips/month. Max quantity for non-insulin utilizers is 100 strips every 3 months. Greater quantities would require prior authorization.***
☐ A4259 Lancets	True Metrix Lancets 28g (100ct) NDC: 56151-0142-60 ***Max quantity for member utilizing insulin is 100 lancets/month. Max quantity for non-insulin utilizers is 100 lancets every 3 months. Greater quantities would require prior authorization.***

Insulin Prescription

Rx

Enter prescription details here

Insulin Type: ______________________

Dosing and Titration: ______________________

To ensure that a brand name product be dispensed, the prescriber must handwrite "Brand Medically Necessary" on the prescription form.

Additional comments:

Frequency of Use: ____________ Quantity: ____________
Refills: ☐ 1 ☐ 2 ☐ 3 ☐ Other: ____________

☐ Pen needles (if using a pen): ☐ 4mm ☐ 5mm ☐ 6mm ☐ 8mm Qty: ____ ☐ Insulin Syringe (if using vials) **Specify size**: ____ Qty: ____

Insulin Pump & Supplies

	Cartridge Change Frequency (A4225)	**Infusion Set Change Frequency (A4224)**
☐ E0784 New Insulin Pump ______________ **Brand Name / Model Number**	☐ Every 3 days (qty 30)	☐ Every 3 days (qty 30)
	☐ Every 2-3 days (qty 40)	☐ Every 2-3 days (qty 40)
☐ E0784 Replacement Pump ______________ **Brand Name / Model Number**	☐ Every 2 days (qty 50)	☐ Every 2 days (qty 50)
	☐ Every 1 day (qty 90)	☐ Every 1 day (qty 90)

Continuous Glucose Monitor (CGM)

Currently on CGM Therapy? ☐ Yes ☐ No Date of Last Visit (Must be within 6 months prior to this visit) ___/___/___

☐ Freestyle Libre ☐ K0554 Reader ☐ K0553 Sensors (monthly)

By my signature below, I authorize the use of this document as a dispensing prescription. I understand that the final decision with respect to ordering this (these) item(s) for this patient is a clinical decision made by me, based on the patient's clinical needs, and that my records concerning this patient support the medical need for the item(s) prescribed.

Provider Name: ______________________ NPI: ____________
Address: ______________________ City: ____________ State: ____ ZIP: ______
Phone: ____________ Fax: ____________ Practice Name: ____________
Notes: ______________________
Provider's Signature: ______________________ Date: ___/___/___