



# 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):**
- |  |   |
|--|---|
| <input type="checkbox"/> E10.65 Type 1 diabetes mellitus with hyperglycemia            | <input type="checkbox"/> E10.9 Type 1 diabetes mellitus without complications |
| <input type="checkbox"/> E11.65 Type 2 diabetes mellitus with hyperglycemia            | <input type="checkbox"/> E11.9 Type 2 diabetes mellitus without complications |
| <input type="checkbox"/> E11.8 Type 2 diabetes mellitus with unspecified complications | <input type="checkbox"/> Z79.4 Long term (current) use of insulin             |

Length of Need: \_\_\_\_\_

## Glucose Monitor & Supplies

<input type="checkbox"/> E0607 Blood Glucose Monitor	True Metrix Meter Kit NDC: 56151-1470-02 <i>*Max quantity is 1 meter/year. Greater quantities would require prior authorization.*</i>
<input type="checkbox"/> A4253 Test Strips	True Metrix Test Strips (50ct) NDC: 56151-1463-04 Frequency of Use: <input type="checkbox"/> Daily <input type="checkbox"/> 2 times daily <input type="checkbox"/> 3 times daily <input type="checkbox"/> More than 3 times a day <i>*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.*</i>
<input type="checkbox"/> A4259 Lancets	True Metrix Lancets 28g (100ct) NDC: 56151-0142-60 <i>*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.*</i>

## Insulin Prescription

<b>R<sub>x</sub></b>	<b>Enter prescription details here</b>	<b>Additional comments:</b>
	Insulin Type: _____ _____ _____ Dosing and Titration: _____ _____ _____ _____	Frequency of Use: _____ Quantity: _____ Refills: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> Other: _____

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

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

## Insulin Pump & Supplies

<input type="checkbox"/> E0784 New Insulin Pump	<b>Cartridge Change Frequency (A4225)</b>	<b>Infusion Set Change Frequency (A4224)</b>
	<input type="checkbox"/> Every 3 days (qty 30) <input type="checkbox"/> Every 2-3 days (qty 40) <input type="checkbox"/> Every 2 days (qty 50) <input type="checkbox"/> Every 1 day (qty 90)	<input type="checkbox"/> Every 3 days (qty 30) <input type="checkbox"/> Every 2-3 days (qty 40) <input type="checkbox"/> Every 2 days (qty 50) <input type="checkbox"/> Every 1 day (qty 90)
_____		
<b>Brand Name / Model Number</b>		
<input type="checkbox"/> E0784 Replacement Pump		
_____		
<b>Brand Name / Model Number</b>		

## 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: \_\_\_\_/\_\_\_\_/\_\_\_\_