omnipod®

INSULIN MANAGEMENT SYSTEM

Insulet Corporation
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30 DAYS of Freedom OMNIPOD® TRIAL PROGRAM

Certificate of Medical Necessity Form

Patient Order Information

Patient Name (First, Middle, Last)	Date of Birth (MM/DD/YYYY)	Gender ○ Male ○ Female

Patient Street Address	Phone Number

City	State	Zip Code

Insulin Pump	Change Frequency: (A9274, K0552, A4222):	Prescription Duration (MM/DD/YYYY)
○ E0784/E0607: Omnipod® System Personal Diabetes Manager (PDM)	○ Every 2-3 days (Qty: Up to 45) ○ Every 3 days (Qty: Up to 40) ○ Every 2 days (Qty: Up to 50) ○ Every 1 day (Qty: Up to 90) **90 Days Supply**	○ Lifetime ○ Expiration Date:

Medical Necessity For Insulin Pump *(check all that apply)*

Current Diabetes Therapy: ○ Insulin Pump ○ Multiple Daily Injections	Latest HbA1c Result	Date (MM/DD/YYYY)	Prior HbA1c Result

Date of Diagnosis (MM/DD/YYYY)	ICD-10 Diagnosis Codes

- ○ Patient/Caregiver has completed diabetes education including carbohydrate counting and is motivated to maintain optimal glucose control
- ○ Patient/Caregiver is motivated, as well as physically and intellectually able to operate the insulin pump
- ○ Patient's current pump therapy technology is out of warranty or its functionality does not meet the patient's medical needs
- ○ Patient has a phobia regarding or aversion to needles
- ○ Work and/or exercise regimen (competitive or prescribed) requires pump to withstand prolonged frequent exposure to water
- ○ Patient has been on multiple daily injections at least 3 times per day for at least 6 months, and is able to self-adjust insulin doses
- ○ Tubing poses an occupational hazard for patient
- ○ Due to impaired vision, patient requires adjustable, high-contrast back-lit colored screen display, not available on current pump
- ○ Blood glucose logs on file show blood glucose is checked 4 or more times a day for the past 2 months

○ Dawn Phenomenon	○ History of Diabetic Ketoacidosis	○ Nocturnal Hypoglycemia without coma
○ Gastroparesis	○ Retinopathy with macular edema	○ Hypoglycemia Unawareness without coma
○ Nephropathy	○ Wide fluctuations in Blood Glucose values: to mg/dL	○ Patient has a CGM and is calibrating 2 times per day
○ Post Renal Transplant	○ Frequent or severe hypoglycemia without coma	○ Patient is pregnant or trying to get pregnant
○ Neuropathy		

Other Conditions:

Prescriber Information

Prescribing Provider Name (First, Last)	NPI

Office Street Address	Phone Number

City	State	Zip Code	Fax Number

Practice Name

Physician Attestation: I certify that I am the Physician identified on this form. I have reviewed the Certificate of Medical Necessity. Any statement on my Letterhead attached hereto, has been reviewed and signed by me. I certify that the medical necessity information is true, accurate and complete, to the best of my knowledge. The patient's record contains supporting documentation which substantiates the utilization and medical necessity of the products listed and will be provided to the distributor upon request. A copy of this order will be retained as part of the patient's medical record.

Physician Signature *(Signature stamps are NOT acceptable)*	Date (MM/DD/YYYY)

Please fax completed form to **877-467-8538** or mail it to the address listed above. If you have any questions, call **800-591-3455**.

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