State of Illinois
Department of Healthcare and Family Services

Certificate of Medical Necessity for External Insulin Infusion Pump

Patient Name: _____ DOB: _____ RIN: _____

Fill in necessary blanks and check boxes where appropriate.

1. Diagnosis: type 1 diabetes mellitus ☐ type 2 diabetes mellitus ☐ Year diagnosed: _____

2. Complications/end organ dysfunction from diabetes

3. Hospitalizations related to poor glycemic control including DKA (diagnoses/dates):

4. Date of most recent evaluation: _____

5. Patient is reevaluated approximately every _____ months.

6. Indicate average daily frequency of glucose self-testing in the past 2 months _____ times per day.

7. Number of daily insulin injections; _____ total daily insulin used: (units) _____

8. Has patient made frequent self-adjustments of insulin dose in last 6 months (at least 3 injections per day)? Yes ☐ No ☐

9. Has patient or caretakers completed a comprehensive diabetes education program? Yes ☐ No ☐

10. If available, submit copies of lab reports for fasting C-peptide with concurrently drawn blood glucose <225 and creatinine clearance for patients with renal insufficiency; and beta cell antibody.

11. HgbA1C: _____ %, Date of most recent: _____

12. History of severe glycemic excursions? Yes ☐ No ☐ Range of glucose values: _____ to _____

13. Wide fluctuations in preprandial blood glucose values commonly exceeding 140 mg/dl or less than 70 mg/dl? Yes ☐ No ☐

14. History of recurring hypoglycemia (less than 60 mg/dl)? Yes ☐ No ☐

15. Has the patient required glucagon for any hypoglycemic events? Yes ☐ No ☐

16. History of dawn phenomenon-fasting blood glucose readings often exceed 200 mg/dl? Yes ☐ No ☐

17. Pregnancy or preconception with history of poor glycemic control? Yes ☐ No ☐

18. Day to day schedule variations such as meal times, work schedule and/or activity level confound degree of regimentation required to self-manage glycemia with multiple daily insulin injections? Yes ☐ No ☐

19. How many times per day is patient expected to test blood glucose? _____

20. How often will the infusion sets/sites be changed? Every _____ days. If more often than every 2 days, explanation must be provided. _____

21. Does the patient or caretakers have the cognitive skills to operate an insulin pump and have the willingness to frequently make blood glucose determinations? Yes ☐ No ☐

22. Has the patient been compliant thus far with the treatment plan? Yes ☐ No ☐

23. Is the patient motivated to achieve and maintain improved glycemic control? Yes ☐ No ☐

24. Is this a replacement insulin pump? Yes ☐ No ☐

Is the pump out of warranty? Yes ☐ No ☐

Explain what is wrong with pump. _____

25. What is the concentration of insulin proposed for use in the new pump? _____ units/ml

I certify that I am a practitioner who manages multiple patients on continuous insulin therapy delivered by an external insulin infusion pump and work closely with a team of nurses, diabetes educators, and dietitians who are knowledgeable in the use of external insulin pump therapy.

_____ _____

Practitioner's Signature with degree: Date

Office Phone #: _____ Fax: _____ NPI: _____