Letter of Medical Necessity - Physician's Written Order

SOLARA MEDICAL SUPPLIES

PATIENT

First: _____ Last: _____ MI: _____ Gender: _____

DOB: _____ Effective Date: _____ Email: _____

Phone: _____ Address: _____

Insurance Provider: _____ Ins. ID: _____

DOCTOR

Doctor Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

NPI#: _____

PRODUCTS

Insulin Pump: _____

Infusion Set / Pods: _____

Cartridges: _____

CGM Device: _____

CGM Sensor Usage: _____

Adult Receiver - Pediatric G4 Users ☐

Test Strips Qty: _____

Lancets Qty: _____

Lancing Device Qty: _____

Control Solution Qty: _____

ADDITIONAL INFORMATION

Diagnosis: _____ _____

Length of Need: 12 months up to 90 day supply

BG testing per day: ____ Insulin Injections per day: ____

Patient is currently using an insulin pump? ☐ No ☐ Yes

Pump out of warranty date: _____

Pump Malfunction/ Upgrade Reason: _____

_____

_____

OTHER

Blood Glucose Meter	Qty: _____
Transparent Film/ Dressing	Qty: _____
Adhesive Wipes / Adhesive Remover	Qty: _____
Glucagon ER Kit	Qty: _____
Pentip Needles / Syringes	Qty: _____
Ketone Strips / Ketostix	Qty: _____
Other: _____	Qty: _____
Other: _____	Qty: _____

The following existing conditions support the start of CSII with the insulin management system. Please mark all applicable conditions.

- ☐ Patient currently checks blood glucose levels 4 or more times per day.
- ☐ Patient has completed a comprehensive diabetes education program.
- ☐ Patient is motivated to maintain optimal control of blood glucose levels of his or her diabetes.
- ☐ Day-to-day variations in work schedule, mealtime and/or activity level, which compound the degree of regimentation required to manage glycemia with multiple insulin injections.
- ☐ AM hyperglycemia (dawn phenomenon) in which fasting blood glucose levels often exceed 200 mg/dl.
- ☐ Patient (or patient's caregiver) has the ability to operate and use an insulin pump and supplies to treat and manage his/her blood glucose.
- ☐ History of suboptimal glycemic control before or during pregnancy.
- ☐ History of nocturnal hypoglycemia
- ☐ Wide variations in preprandial blood glucose levels (commonly exceeds 100 mg/dl).
- ☐ Patient has been on a program of multiple daily injections with frequent self-adjustment of insulin dose for at least 6 months prior to the initiation of the insulin pump.
- ☐ History of severe glycemic excursions (commonly associated with brittle diabetes, extreme insulin sensitivity, hypoglycemic awareness, nocturnal hypoglycemia and/or very low insulin requirements).
- ☐ Inadequate glycemic control despite appropriate adjustments in insulin therapy and compliance with frequent self monitoring.
- ☐ Recurring episodes of severe hypoglycemia (<50 mg/dL)
- ☐ History of hypoglycemic unawareness

I certify that I am the physician identified on this form. I have reviewed the Physician's Written Order. 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. I certify that patient/caregiver is capable and has successfully completed training or will be trained on the proper use of the products prescribed on this written order. The patient's record contains supporting documentation that substantiates the utilization and medical necessity of the products used and physicians notes and other support documentation will be provided to Solara Medical upon request. I understand any falsification or omission of material fact in that section may subject me to civil or criminal liability. A copy of this order will be retained as part of the patient's medical record.

_____ _____ _____

Physician Name Printed Physician Signature Date