External Insulin Pump Prior Authorization Form

Prior Authorization Request Submitter Certification Statement

I certify and affirm that I am either the Provider, or have been specifically authorized by the Provider (hereinafter "Prior Authorization Request Submitter") to submit this prior authorization request.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that they are personally acquainted with the information supplied on the prior authorization form and any attachments or accompanying information and that it constitutes true, correct, complete and accurate information; does not contain any misrepresentations; and does not fail to include any information that might be deemed relevant or pertinent to the decision on which a prior authorization for payment would be made.

The Provider and Prior Authorization Request Submitter certify and affirm under penalty of perjury that the information supplied on the prior authorization form and any attachments or accompanying information was made by a person with knowledge of the act, event, condition, opinion, or diagnosis recorded; is kept in the ordinary course of business of the Provider; is the original or an exact duplicate of the original; and is maintained in the individual patient's medical record in accordance with the *Texas Medicaid Provider Procedures Manual* (TMPPM).

The Provider and Prior Authorization Request Submitter certify and affirm that they understand and agree that prior authorization is a condition of reimbursement and is not a guarantee of payment.

The Provider and Prior Authorization Request Submitter understand that payment of claims related to this prior authorization will be from Federal and State funds, and that any false claims, statements or documents, concealment of a material fact, or omitting relevant or pertinent information may constitute fraud and may be prosecuted under applicable federal and/or State laws. The Provider and Prior Authorization Request Submitter understand and agree that failure to provide true and accurate information, omit information, or provide notice of changes to the information previously provided may result in termination of the provider's Medicaid enrollment and/or personal exclusion from Texas Medicaid.

The Provider and Prior Authorization Request Submitter certify, affirm and agree that by checking "We Agree" that they have read and understand the Prior Authorization Agreement requirements as stated in the relevant Texas Medicaid Provider Procedures Manual and they agree and consent to the Certification above and to the Texas Medicaid & Healthcare Partnership (TMHP) Terms and Conditions.

☐ We Agree

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Submit requests for a tubeless insulin pump for clients 20 years of age or younger with a completed CCP Prior Authorization Request Form or detailed orders to TMHP CCP Fax: 512- 514-4212
Submit all other requests with a completed Home Health Services (Title XIX) DME/Supplies Physician Order Form or detailed orders to TMHP Home Health Fax: 512-514-4209

Client Information			
Client Name	Last:	First:	Middle Initial:
Medicaid Number:		Date of birth:	

Prescribing Provider Information **(must be a physician, physician assistant, nurse practitioner, clinical nurse specialist, or certified nurse midwife)**	
Name:	License number:
Telephone:	Fax number:
TPI:	NPI:

A. Rental of External Insulin Pump

For clients diagnosed with Type 1 or Type 2 diabetes, please check which of the following conditions apply (to be considered at least two conditions must apply):

- ☐ Elevated glycosylated hemoglobin level (HbA1c) > 7.0%
- ☐ History of dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl
- ☐ History of severe glycemic excursions with wide fluctuations in blood glucose
- ☐ History of recurring hypoglycemia (less than 60 mg/dL) with or without hypoglycemic unawareness
- ☐ Anticipation of pregnancy within 3 months

For clients with gestational diabetes, please check which of the following conditions apply (to be considered at least one condition must apply):

- ☐ Erratic blood sugars in spite of maximal compliance and split dosing
- ☐ Other evidence that adequate control is not being achieved by current methods
  Describe evidence if checked:

B. The prescribing provider signature attests to all of the following:

1. The client and or caregiver possess the cognitive and physical abilities to follow recommended insulin pump treatment regimen, an understanding of cause and effect, and the willingness to support the use of the external insulin pump.
2. A training/education plan will be completed prior to initiation of pump therapy.
3. The client and/or caregiver will be given face-to-face education and instruction and will be able to demonstrate proficiency in integrating insulin pump therapy with their current treatment regimen for ambient glucose control.

Prescribing Provider Signature:	Date: