External Insulin Pump Prior Authorization Form

Submit your prior authorization using TMHP's PA on the Portal and receive request decisions more quickly than faxed requests. With PA on the Portal, documents will be immediately received by the PA Department, resulting in a quicker decision. To access PA on the Portal, go to www.tmhp.com and select "Prior Authorization" from the Topics drop-down menu. Then click the PA on the Portal button and enter your TMHP Portal Account user name and password. Fax requests must be scanned and data entered before the PA Department receives them, which can take up to 24 hours. To submit by fax, send to **512-514-4209**.

Note: *If any portion of this form is incomplete, it may result in your prior authorization request being pended for additional information.*

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**

External Insulin Pump Prior Authorization Form

All external insulin pump requests must be submitted with a completed Home Health Services (Title XIX) DME/Supplies Prescribing Provider Order Form.

Note: *Fields marked with an asterisk below indicate an essential/critical field. If these fields are not completed, your prior authorization request will be returned.*

A. Client Information

First Name*:	Last Name*:	Middle Initial:
Medicaid Number*:	Date of Birth*:	

B. Rendering Provider Information

Provider Name* (*please print*):			
Telephone:	Fax:		
Street Address*:			
City:	State:	ZIP + 4*:	
Tax ID*:	NPI*:	Taxonomy*:	Benefit Code*:

C. Return of External Insulin Pump

For clients diagnosed with Type 1 or Type 2 diabetes, please check which of the followlng 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 200mg/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:

D. The requesting 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.

Requesting Provider Signature:	Requesting Provider NPI*:	Date: