MASSHEALTH PRESCRIPTION AND MEDICAL NECESSITY REVIEW FORM FOR AMBULATORY INFUSION (INSULIN) PUMPS

MassHealth
THE COMMONWEALTH OF MASSACHUSETTS
Executive Office of Health and Human Services

Sections 1, 2, 3, 4, 5, and 6 must be completed by the provider of durable medical equipment and supplies (DME). Sections 4A (shaded below), 5A (shaded below), and 7 must be completed by the prescribing provider or his/her employee. Section 8 must be completed by the prescribing provider.

SECTION 1

Member Name			Date of Delivery / /
Address			Telephone No.
MassHealth ID No.	Date of Birth / /	Gender	Height	Weight
Primary ICD Code	Description		
Secondary ICD Code	Description		

SECTION 2

Prescribing Provider's Name	NPI No.
Address	
Telephone No.	Fax No.

SECTION 3

Name of Provider of DME	NPI No.
Address	
Telephone No.	Fax No.

SECTION 4 Ambulatory Infusion (Insulin) Pumps Only

Please enter the appropriate HCPCS code, modifier, and description of equipment.

SECTION 4A

(Must be completed by the prescribing provider or by the prescribing provider's employee.)

Description of Item(s) Being Requested	HCPCS Code	Modifier	Length of Need

SECTION 5 Pump Supplies Only

Please enter the appropriate HCPCS code, modifier, and description of the supplies.

SECTION 5A

(Must be completed by the prescribing provider or by the prescribing provider's employee.)

Description of Item(s) Being Requested	HCPCS Code	Modifier	Quantity Monthly	Number of Refills

SECTION 6

Provider of DME Attestation, Signature, and Date

I certify under the pains and penalties of perjury that the information on this form and any attached statement that I have provided has been reviewed and signed by me, and is true, accurate, and complete, to the best of my knowledge. I also certify that I am the provider or, in the case of a legal entity, duly authorized to act on behalf of the provider. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Signature of provider of DME (Signature and date stamps, or the signature of anyone other than the provider of DME or a person legally authorized to sign on behalf of a legal entity, are not acceptable.)

Printed legal name of provider:	Date / /
Printed legal name of individual signing (if the provider is a legal entity)	

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Member Name: ____________________

SECTION 7

Section 7 must be completed by the member's prescribing provider or the provider's staff. Please attach any pertinent information (for example, lab tests, medical history and physical examination, or clinical notes, etc).

1) What co-morbidities are present? Please list the ICD code.
   - ☐ Retinopathy ____________________
   - ☐ Nephropathy ____________________
   - ☐ Neuropathy ____________________
   - ☐ Other: ____________________

2) What was the date of the member's most recent HbA1c? ____________ What was the value? ____________
   Other relevant tests (specify): ____________________

3) H ow many injections of insulin does the member self-administer a day?
   - ☐ one to three times a day
   - ☐ three to six times a day
   - ☐ six to nine times a day
   - ☐ 10 or more times a day
   - ☐ Other (specify): ____________________

4) Does the member frequently adjust his/her insulin dosage? . . . . ☐ Yes ☐ No
   Please explain how often the dosage is adjusted. ____________________
   How long has the member been adjusting his/her dosage of insulin? ____________________

5) D oes the member have a history of recurring hypoglycemia? . . . . ☐ Yes ☐ No
   How often? ____________________

6) Does the member have wide fluctuations in blood glucose before mealtime? . . . . ☐ Yes ☐ No
   Please list the three most recent ranges
   From ________ to ________ mg/dL From ________ to ________ mg/dL From ________ to ________ mg/dL

7) Does the member have dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL? . . . . ☐ Yes ☐ No
   How often in the last 30 days? ____________________

8) Does the member have a history of severe glycemic excursions? . . . . ☐ Yes ☐ No
   Please explain. ____________________

9) Does the member have a history of prior treatment with MDIs (multiple daily injections) that have been tried and not been effective in managing blood sugars or medical symptoms? . . . . ☐ Yes ☐ No
   Please explain. ____________________

10) Is the member motivated to maintain optimal control of his/her diabetes? . . . . ☐ Yes ☐ No
    Please explain. ____________________

11) Does the member demonstrate a willingness to adhere to a proper diet and exercise regimen? . . . . ☐ Yes ☐ No
    Please explain. ____________________

12) Does the member have the ability to operate the pump? . . . . ☐ Yes ☐ No

SECTION 8

Prescribing Provider's Attestation, Signature and Date

I certify under the pains and penalties of perjury that I am the prescribing provider identified in Section 2 of this form. Any attached statement on my letterhead has been reviewed and signed by me. I certify that the medical necessity information (per 130 CMR 450.204) on this form is true, accurate, and complete, to the best of my knowledge. I understand that I may be subject to civil penalties or criminal prosecution for any falsification, omission, or concealment of any material fact contained herein.

Prescribing provider's signature (Signature and date stamps, or the signature of anyone other than the prescribing provider, are not acceptable.)

____

Check applicable credentials: ☐ MD ☐ NP ☐ PA

Printed name of prescribing provider: ____________________ Date / /

Instructions for Completing the MassHealth Prescription and Medical Necessity Review Form for Ambulatory Infusion Pumps (Insulin Pumps)

Sections 1, 2, 3, 4, 5, and 6 must be completed by the provider of DME. Sections 4A, 5A, and 7 must be completed by the prescribing provider or his/her employee. Section 8 must be completed by the prescribing provider.

Instructions for the Use of this Form	Providers of DME should use this form when obtaining a Prescription and Letter of Medical Necessity from the member's prescribing provider for Ambulatory Infusion Pumps (Insulin Pumps), and as an attachment to a prior authorization (PA) request for insulin pumps. Providers of DME are responsible for ensuring compliance with applicable MassHealth regulations and guidelines when using this form. MassHealth reserves the right not to accept the form if it is completed improperly, or if the provider has failed to meet applicable MassHealth regulations, requirements, and guidelines, including without limitation medical necessity requirements. Please refer to the ***MassHealth Guidelines for Medical Necessity Determination for Ambulatory Infusion Pumps (Insulin Pumps)*** for further information about required clinical documentation and information that must be submitted for PA requests for ambulatory infusion pumps (insulin pumps). A copy of this completed form (including all attachments and supporting documentation) must be maintained in the member's medical record at the prescribing provider's office and at the provider of DME's office.
Section 1	Enter the date of delivery of ambulatory infusion pumps (insulin pumps) at the top of the form. The date of delivery on this form must match the date on the delivery slip. Enter the member's name, MassHealth member ID, address (including apartment number if applicable) telephone, date of birth, gender, height, weight, and applicable ICD diagnosis code(s) with their descriptions.
Section 2	Enter the prescribing provider's name, NPI, address, telephone, and fax number.
Section 3	Enter name of provider of DME, NPI, address, telephone, and fax number.
Section 4	Enter the description of the **ambulatory infusion pump(s) (insulin pump(s))** being requested, the correct HCPCS code(s), and the modifier(s). Please do **not** list pump supplies in Section 4, but separately complete Section 5 for that purpose. Please be sure to use the correct modifier for the length of time you are requesting.
Section 5	Enter the description of the **pump supplies** being requested, if any, for use with the ambulatory infusion pumps (insulin pumps), along with the correct HCPCS code(s) and modifiers.
Section 6	The provider of DME must sign and enter the date the form was completed. By signing the form, the provider is making the certifications contained above the signature line. **Note: Signature and date stamps, or the signature of anyone other than the provider of DME or a person legally authorized to sign on behalf of a legal entity (if the provider of DME is a legal entity), are not acceptable.**
Sections 4A, 5A, and 7 must be completed by the prescribing provider or his/her employee.	
Section 4A	The prescribing provider(or his/her employee) must enter the total number of months that the prescribing provider expects the member will require use of the ambulatory infusion pump (insulin pump). The total number of months cannot exceed 13 months from the date of the original prescription.
Section 5A	The prescribing provider or his/her employee must enter the total monthly quantity of pump supplies and the number of refills. The total number of months cannot exceed 13 months from the date of the original prescription.
Section 7	The member's prescribing provider or his/her staff must complete the medical justification for the requested product(s). This section must be filled in, and applicable supporting documentation must be attached.
Section 8 must be completed by the prescribing provider.	
Section 8	The member's prescribing provider listed in Section 2 of this form must review all information completed on and attached to this form, and must sign and date the form. By signing the form, the prescribing provider is making the certifications contained above the signature line. **The form must be signed by the member's prescribing provider, who must be either the member's physician (MD), nurse practitioner (NP), or physician assistant (PA). The prescribing provider must check the applicable credential(s).**

If you have any questions about how to complete this form, please contact the MassHealth Customer Service Center at **1-800-841-2900**.