KAISER PERMANENTE®

Kaiser Foundation Health Plan of Washington

Insulin Pump Request for New Pump Start

_____New Pump Start - Vendor ❑ Byram Healthcare ❑ Other ______________________
_____*(Secondary Request)* **Requesting Pump Start with Certified Trainer outside Kaiser Permanente (KP)**

Endocrinology

Patient name:	________________________	Consumer number:	________________________
Date of birth:	________________________	PCP:	________________________
Referring provider:	________________________	Location:	________________________
Phone:	________________________	E-mail:	________________________

Primary Care

Step 1:

- Determine basic clinical appropriateness for insulin pump therapy.
- Refer patient to an Endocrinology Service and state in request that patient is to be evaluated for an insulin pump. For any questions regarding where to refer, go to Review Services Resource Guides (http://dsapp01.ghc.org/rrg/rfrlguide2.nsf/WelcomePage?OpenPage). Select the specific area and click "Specialty". Choose Endocrinology from the category option at top of the page to get current list of contracted endocrinology providers.

Endocrinology Service (KP Endocrinology or contracted endocrinology provider)

Step 2:

- Referring Endocrinology service must complete all documentation on this page and faxed to Kaiser Permanente Review Services. Include signed documentation of Kaiser Permanente Insulin Pump Supervision Agreement Form for Children if patient is under 18 and/or documented 'exception' criteria if such applies to this request.

- Patient has been prepared to start pump (one-on-one and/or class) and has demonstrated ability to: (check off each completed activity)
  ____Medicare Patients - Fasting C-Peptide and Fasting blood glucose (BG) OR beta-cell autoantibody positivity documented in patient chart.
  ____Learn and apply carbohydrate counting (or equivalent).
  ____Practice safe and appropriate use of regimen of long acting and very rapid acting insulins.
  ____Use BG monitoring plan (4 X per day minimum) that includes record log and pattern management.
  ____Describe appropriate treatment for both hyper or/and hypoglycemia situations.
  ____Assessed as emotionally stable and able to implement diabetes self-management safely and appropriately (CSII therapy is not appropriate for ETOH/substance abuse or severe mental illness).
  ____One-on-one, class, or group education for pump management assessed and completed:
  Date:____________Location:______________________Instructor of Record: ______________________

- Requesting approval for pump to be started by certified pump trainer (name): __________________________

- Based on evaluation of signed provider, does this patient meet clinical criteria for pump replacement?
  Yes____No ____
  (Documentation of reason(s) for exception(s) to medical necessity criteria must be included with fax)

- List Requested Insulin Pump Brand and Model #: ____

Signed: ______________________________________ Date: ___________________________
(Endocrinologist/ ARNP) Endo Phone: ___________________________

Fax this completed form to Kaiser Permanente Review Services 1-844-660-0717.

Sent by: ______________________________________ Date: ___________________________
Contact Phone ___________________________

Review date: 7/18/2023

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