KAISER PERMANENTE®

Kaiser Foundation Health Plan
of Washington

Insulin Pump Replacement Request

____Replacement or upgrade. 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:	______________________

Note If insulin pump is currently under warranty (within 4 years of original purchase or timeframe per manufacturer), the patient may choose to upgrade directly with pump manufacturer. There is usually a fee (paid to the pump vendor) for this upgrade or change. The vendor's clinical service personnel may then assist the patient with needed training, or the patient can arrange to have the pump training scheduled via his/her endocrinology service.

If pump is currently under warranty and endocrinology service makes a request for a newer model, the reason for replacement must be well documented. This request may result in the patient accepting full cost or an uncovered benefit portion of this replacement pump.

Primary Care

Step 1:

- If patient requests or needs insulin pump replacement, refer to KP Endocrinology Service and state in request that patient is to be evaluated for insulin pump replacement. For questions regarding where to refer consult the Insulin Pump Handbook.

Endocrinology Service (KP Endocrinology or contracted endocrinology provider)

Step 2: Assessment of patient need for pump replacement (must be "yes" to both 1 and 2)

1. Will newer model pump provide patient with clinically therapeutic features necessary to achieve improvement in glycemic control? Yes__No ____

2. Patient is currently participating in day to day management necessary for appropriate and safe insulin pump management (including: testing blood glucose (BG) 4 or more times per day; doing necessary problem solving; able to trouble- shoot pump; keeps appropriate records of BG, insulin, glycemic events; has time to learn new model pump; not currently experiencing major transitions or stresses that would detract from pump management)? Yes______No ____

3. Is current pump still under warranty (per manufacturer)? Yes_____ No ______
(Documentation explaining why replacement is clinically warranted at this time must be included with fax)

4. 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)

5. List Requested Insulin Pump Brand and Model #: ________________________________

Signed: ______________________________ Date: ______________________
(Endocrinologist/ ARNP) Endo Phone: ______________________

Endocrinology Service must FAX this completed form to Kaiser Permanente Review Services 1-844-660-0717.

Sent by: ______________________________ Date: ______________________

Contact Phone ______________________