

Certificate of Medical Necessity

This letter serves as a Certificate of Medical Necessity for the device(s) indicated below and/or related supplies to be provided by Animas Canada for the below referenced patient: (Check all that apply)

- | | |
|---|---|
| <input type="checkbox"/> Animas® Vibe® insulin pump | <input type="checkbox"/> OneTouch® Ping® insulin pump |
| <input type="checkbox"/> Animas® Vibe® insulin pump and CGM | <input type="checkbox"/> Dexcom G4® PLATINUM Continuous Glucose Monitoring (CGM) System |

PATIENT INFORMATION

Patient Name (Last Name, First Name) _____

Patient DOB (mm/dd/yyyy) _____ / _____ / _____

Address _____

City _____ Province _____ Postal Code _____

STATEMENT OF MEDICAL HISTORY

The patient has Type ____ diabetes. Date Diagnosed: Month _____ Year _____

- Patient is using Multiple Daily Injections
- Patient is using an Insulin Pump
- Patient is using a Continuous Glucose Monitor (CGM)

Recent A1c:	A1c _____,	Date (mm/dd/yyyy) _____ / _____ / _____
	A1c _____,	Date (mm/dd/yyyy) _____ / _____ / _____
	A1c _____,	Date (mm/dd/yyyy) _____ / _____ / _____

Diabetes Related Complications: _____

SUPPORTING CLINICAL INDICATIONS

(Check all that apply)

- Suboptimal glycemic and metabolic control.
- History of severe glycemic excursions (commonly associated with labile diabetes, hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity, and/or insulin requirements).
- Recurring episodes of severe hypoglycemia.
- Evidence of unexplained hypoglycemia episodes.
- Preconception or pregnancy with a history or suboptimal glycemic control.
- Elevated fasting blood glucose due to dawn phenomenon.
- Wide fluctuation in blood glucose levels before and after meals..
- Poor glycemic control as evidenced by CGM sensing trial.
- Day to day variations in schedule, mealtimes, and/or activity level which makes it difficult to self-manage with MDI or conventional pump therapy.
- Patient has completed comprehensive diabetes education.
- Patient has demonstrated ability to self-monitor blood glucose levels as recommended by Physician.
- Patient is motivated to achieve and maintain improved glycemic control.
- Warranty on current device has expired.
- Other: _____

PHYSICIAN INFORMATION

Physician Name _____

Hospital/Clinic Name _____

Address _____

City _____ Province _____

Postal Code _____

Telephone (_____) _____

Fax (_____) _____

Email _____

I certify that the information contained in this document is true, accurate, and complete.

Physician Signature _____

Date (mm/dd/yyyy) _____ / _____ / _____

Email, fax or mail this completed form to Animas Canada:

Animas Canada, 200 Whitehall Drive, Markham, ON L3R 0T5

Tel: 1.866.406.4844 Fax: 1.866.406.4033 Email: CustomerCare@Animas.ca