

**Criteria Checklist**  
**MUST ACCOMPANY THE PRIOR AUTHORIZATION FORM**

**Alabama Medicaid Agency**  
**External Ambulatory Insulin Infusion Pump (E0784)**  
Children under 21 years of age and EPSDT eligible

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**PREREQUISITE CRITERIA** *The patient must meet all of the following:*

- Patient must be Medicaid eligible, less than 21 years of age, and EPSDT eligible.
- Patient must have a documented\* diagnosis of insulin dependent diabetes mellitus (IDDM, also known as type I).
- A board certified endocrinologist must have evaluated the patient and ordered the insulin pump.
- Patient must have been on a program of multiple daily injections (MDI) of insulin (i.e., at least three injections per day) for at least six months prior to initiation of the insulin infusion pump. Supporting documentation\* must be submitted.
- Patient has documented frequency of glucose self-testing (i.e. patient "logs") an average of at least four times per day during the three months prior to initiation of the insulin pump. Patient must include six consecutive weeks' worth of logs within the three months prior to the prior authorization request.
- Patient and/or caregiver must be capable, physically and intellectually, of operating the pump. Patient/caregiver must demonstrate ability and commitment to comply with regimen of pump care, diet, exercise, medications, and glucose testing at least four times a day. Supporting documentation\* must be submitted.
- Education on insulin pump MUST have been conducted prior to prior authorization request, and each the patient, caregiver if child, and educator signed to document\* their understanding.
- Documentation\* of active and past recipient compliance with medications and diet, appointments, and other treatment recommendations must be provided.

**ADDITIONAL CRITERIA** *The patient must also meet one or more of the following, supported by documentation\*:*

- Two elevated glycosylated hemoglobin levels (HbA1c > 7.0%) within a 120-day time span, while on multiple daily injections of insulin.
- History of severe glycemic excursions (commonly associated with brittle diabetes, hypoglycemic unawareness, nocturnal hypoglycemia, extreme insulin sensitivity and/or very low insulin requirements).
- Widely fluctuating blood glucose levels before mealtime (i.e., pre-prandial blood glucose level consistently exceeds 140 mg/dL).
- Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL.

**RECERTIFICATION/RENEWAL:**

For patients who have received external ambulatory insulin infusion pump equipment and supplies through Alabama Medicaid and are in need of a Prior Authorization Renewal, an updated prescription and an attestation from the patient's prescribing provider, stating their recommendation for continued use of the insulin delivery system/pump and pods, is required.

**DIAGNOSIS CODES**

Approval will be given for only type I diabetes mellitus diagnosis codes. Please refer to Chapter 14 of the Provider Manual for the ICD-10 crosswalk codes.

**PROCEDURE CODES**

E0784, A4221, A4232, A4230, A9274

Maximum yearly limits apply to each of the procedure codes indicated above. Requests for replacement of E0784 will be limited to once every five years based on a review of submitted documentation requested.

*\*Documentation may include notes from the patient chart and/or pharmacy printouts (to support medication compliance history).*

I certify that this treatment is indicated and necessary and meets the guidelines for use as outlined by the Alabama Medicaid Agency. I will be supervising the patient's treatment. Required supporting documentation from the patient's medical record is attached.

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Prescribing Practitioner Signature (Required)  
(Stamps/copies of physician's signature will not be accepted)

Date