Animas CORPORATION
a Johnson & Johnson company

Certificate of Medical Necessity

1. Patient Information

Patient Name: _____ Telephone: _____

Date of Birth: _____ Patient ID Number: _____

This certificate serves as a Prescription and Statement of Medical Necessity for Pump/Testing supplies.

2. Diagnosis ICD 10

DX Code:
- ☐ E10.9 — **Type 1 without Complications**
- ☐ E11.65 — **Type 2 w/ Hyperglycemia**
- ☐ E10.65 — **Type 1 w/ Hyperglycemia**
- ☐ Other: _____ — **MUST BE an ICD 10 code**

3. Management and Assessment

Date last seen: Month _____ Day _____ Year _____

4. Infusion Set and Cartridge Changes

Prescribed for a lifetime

Infusion sets and cartridges - check box for frequency and quantity:

- ☐ Every 2 days - Quantity 50
- ☐ Every 2-3 days - Quantity 40
- ☐ Every 3 days - Quantity 30
- ☐ Every 1 day - Quantity 90 Reason:_____
- ☐ Other: _____ Quantity: _____ Reason: _____

5. Testing Supplies: How many times per day the patient is expected to check his/her blood glucose

Estimated number of strips and lancets prescribed for a 90-day period (check the appropriate box):

☐ 4/day=400; ☐ 5/day=450; ☐ 6/day=550; ☐ 7/day=650; ☐ 8/day=750;
☐ 9/day=850; ☐ 10/day=900; ☐ Other: _____

6. Testing supplies prescribed for a 12-month period: Check the appropriate box

☑ Meter; ☑ Lancets; ☑ Control solution; ☑ Lancing device; ☑ Batteries;
☑ Strips; ☑ Transparent film; ☑ Skin barrier swabs; ☑ Alcohol wipes;
☑ Spring powered device for lancet

I certify that the above information is correct.

Healthcare Provider's Signature:_____ **Date Signed:**_____

Healthcare Provider Information (Printed):

Healthcare Provider:_____ **Office Contact:**_____

Address:_____ **City:**_____ **State:**_____ **ZIP:**_____

Phone Number:_____ **Fax Number:**_____ **NPI:**_____

Please fax the latest progress note and this document to: