DIABETES SERVICES – effective AUG 2022

****PRESCRIPTION FORM FOR OB HOMECARE SERVCIES****

Fax signed form to : 866-252-4293 or 866-731-9011 – OR – scan signed form to email: OBHIntake@optum.com

NOTE: COPY OF CURRENT INSURANCE CARD (FRONT AND BACK) MUST ACCOMPANY THIS SUBMISSION. Initiate and manage homecare **PER OPTUM PROTOCOLS** as provided for the following services or prescriber to call Optum (800-950-3963) for other orders.

PATIENT INFORMATION

Name: _____ Phone: _____
Address: _____City: _____ State: _____ Zip Code: _____
DOB: _____ Due Date: _____ Ht:_____ Wt: _____ Allergies: _____
Patient Location (at time of referral): ❑ Home ❑ Hospital (name): _____
Preferred Language: ❑ English ❑ Other: _____
Insurance Carrier Name, Policy #, phone #: _____
Form Completed by: (Name, title): _____ Phone #: _____

SERVICE REQUESTED (start of service will occur upon verification and patient accepts care)	BASED ON THE FOLLOWING CRITERIA
INSULIN INJECTION SERVICE ❑ **DIABETES MANAGEMENT** via insulin injection service (daily management includes blood glucose meter, supplies, instruction in blood glucose monitoring and urine ketone testing. Culturally sensitive individualized meal/snack planning and exercise guidance. Also includes insulin below, insulin supplies and glucose tablets. **[Select One]** ❑ **OPTUM** to provide/dispense Novolin R and Novolin N vials OR ❑ **PATIENT** to obtain insulin/medication through prescriber prescription. **Management Orders**: If patient is taking oral antidiabetic agent, discontinue at start of insulin. **[Choose only one]** ❑ **Per Optum protocol** – Optum to calculate initial dose and adjust ongoing insulin dosing requirements individualized per gestational age, weight and clinical criteria within range of 0.6 to 1.0 units/kg/day (BG targets: fasting=60-95, 2 hr pp= 65-119). Prescriber will receive patient specific information on plan of treatment at start of care. ❑ **Patient not following Optum protocols** for management and adjustment: contact prescriber for initial dosing and ongoing orders. ❑ **Follow** my signed standing protocol previously approved by Optum and on file. (Available for large volume providers only.)	(check all that apply) ❑ Patient needs support resources for tight control. ❑ Glucose out-of-range with diet and/or oral agent. Highest BG recorded: _____
INSULIN PUMP SERVICE ❑ **DIABETES MANAGEMENT** via SQ insulin service (daily management includes blood glucose meter and supplies, instruction in blood glucose monitoring and urine ketone testing, culturally sensitive, individualized meal/snack planning and exercise guidance. Also includes insulin below, insulin supplies, pump and pump supplies and glucose tablets. **[Select all that apply]** ❑ **OPTUM** to provide SQ pump, Novolog (for pump) and Novolin NPH vial (for pump interruption) ❑ **PATIENT** to obtain insulin/medication through prescriber prescription ❑ **PATIENT** to obtain or has own pump **Management Orders**: If patient is taking oral antidiabetic agent, discontinue at start of insulin pump. **[Choose only one of the following 3 options]** ❑ **Per Optum protocol-** Optum to calculate initial dose and adjust ongoing insulin requirements individualized per gestational age, weight and clinical criteria within range of 0.6 to 1.0 units/kg/day (fasting and pre-meal = 60-89 and 2 hr pp = 65-119). Prescriber will receive patient specific information on plan of treatment at start of care. ❑ **Prescriber to select here if desires 1 hr pp 100-129 (instead of 2 hr pp)** ❑ **Patient not following Optum protocols** for management and adjustment: contact prescriber for initial insulin dosing and ongoing orders. ❑ **Follow** my signed standing protocol previously approved by Optum and on file. (Available for large volume providers only.)	(check all that apply) ❑ Patient needs support resources for tight control. ❑ Glucose out-of-range with diet and/or oral agent. Highest BG recorded: _____

INTIAL PRESCRIBER (Signature Required)

Practice Name: _____ Office Contact: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Phone/Extension:_____ Fax: _____ Email: _____

IF ONGOING CARE OF THIS PATIENT WILL BE MANAGED BY ANOTHER PROVIDER, COMPLETE THE INFORMATION BELOW. As the prescriber, you are responsible for full care of this patient unless/until the ongoing managing provider's prescription is received by Optum. At that time, all care responsibilities for this patient will be transferred to the alternate provider and the initial patient care prescription is discontinued.

Providers Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____

I certify that this patient is under my care and that the above services are medically necessary and are authorized by me with the above written plan of treatment. My signature acknowledges that (i) I have received and reviewed the protocol that accompanies this plan of treatment and understand and accept responsibility for the patients care, and (ii) my state medical license is current and valid as indicated below. Start of service will occur upon completion of benefits and eligibility, verification, receipt of medication from dispensing pharmacy and patient agreement to start of service date.

PRESCRIBER SIGNATURE:_____ (Print Name): _____
NPI#: _____ License#: _____ State: _____ Date: _____

For Internal Use Only: Telephone Order From: _____
❑ RBV By (Optum Nurse): _____, RN Date: _____ Time: _____
❑ Prescription reviewed by Optum RN: _____Date: _____