Animas® CANADA
a division of LifeScan Canada Ltd.

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)

- ☐ Animas® Vibe® insulin pump
- ☐ Animas® Vibe® insulin pump and CGM
- ☐ OneTouch® Ping® insulin pump
- ☐ 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

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