HEALTH NET FEDERAL SERVICES
A Wholly-Owned Subsidiary of Centene Corporation

TRICARE®

Beneficiary Full Name: ______________________________ Sponsor's SSN: ______-_____-_______

Date of Birth: ______________________________ Beneficiary State of Residence: ______________

Dear Provider,

Please complete the letter of attestation below and return as indicated on the additional information request letter.

TRICARE Policy Manual, Chapter 8, Section 2.3 authorizes coverage of insulin pumps for individuals with diabetes when coverage criteria are met.

Please select the type of insulin pump requested:

☐ Valeritas V-Go®™ Disposable Insulin Delivery Device (V-Go). **Please complete Section 1 below.**

☐ All other insulin pumps. **Please complete Section 2 below.**

Section 1

In order for the V-Go to be considered for covered, the provider must attest all criteria apply:

☐ The patient has Type 2 diabetes mellitus;

☐ the patient does not need more than 40 units of basal insulin or more than 36 units of bolus insulin daily;

☐ the patient does not need less than two unit increments of bolus dosing;

☐ the patient has been maintained on stable basal insulin for at least three months (at dosages of 20U, 30U, or 40U); and

☐ the patient has been using prandial insulin for at least three months.

Section 2

In order for an insulin pump (other than V-Go) to be considered for covered, the provider must attest all criteria apply:

☐ The beneficiary has Type 1 diabetes mellitus and there is documentation by the physician of poor diabetic control;

☐ the beneficiary has Type 2 diabetes mellitus and there is documentation by the physician of poor diabetic control and the patient has failed to achieve glycemic control after six months of multiple daily injection therapy; and

☐ the beneficiary has cystic fibrosis related diabetes and there is documentation by the physician of poor diabetic control.

I attest the information provided is true and accurate to the best of my knowledge. I understand Health Net Federal Services, LLC or designee may perform a routine audit and request the medical documentation to verify the accuracy of the information reported on this form.

Additional information: ______________________________

Physician's printed name and title: ______________________________

TIN: ______________________________

Signature: ______________________________ Date: ______________

This document may contain information covered under the Privacy Act (5 USC §552a) and/or the Health Insurance Portability and Accountability Act (P.L.104-191) and its various implementing regulations and must be protected in accordance with those provisions. If you have received this correspondence in error, please notify 1-844-866-WEST (9378) at once and destroy the documents and any copies you have made.

Authorizations and Referrals • PO Box 9108 • Virginia Beach, VA 23450-9108

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