New Brunswick Insulin Pump Program (IPP)  
Approval Authorization Form

This form consists of five sections.

Each section is to be completed by a member of the applicant’s diabetes care team. The prescribing physician completes Sections 1, 2, and 3. These are reviewed by the client’s Diabetes Education Clinic.

Sections 4 and 5 are completed by the client and/or family and submitted directly to the IPP Business Office.

The application must be completed in full to be begin processing.

The Approval Authorization Form includes the following components:

**Completed by Physician specialist**

- **Section 1 – Basic Demographic**
- **Section 2 – Medical criteria and Confirmation of Eligibility**
- **Section 3 – Device and Supplies Requested**

The physician’s office forwards Sections 1, 2, and 3 to the client’s Diabetes Education Clinic (DEC). The DEC reviews and submits the Sections 1, 2, and 3 to the IPP Business Office for processing.

**Add medical criteria and confirmation eligibility notes to the “Notes” area of Section 3**

**Completed by Client or Family/Guardian**

- **Section 4 – Financial Contribution Assessment**
- **Section 5 – Release of Information**

The client/family/guardian will mail the completed Sections 4 and 5 along with the supporting documentation to the IPP Business Office for processing.

For further information or assistance call 1-855-655-5525.
New Brunswick Insulin Pump Program (IPP)
Approval Authorization Form

Section 1 - Basic Demographic

Name of Applicant: ___________________________ Date of Birth: (MM/DD/YYYY) ___________________________

Applicant’s Current Mailing Address: ___________________________ Medicare Number: ___________________________

Applicant’s Current Telephone Number

Home ___________________________ Cell ___________________________

Child (under 19) lives with: ___ Mother only ___ Father only ___ Both parents ___ Other: ___________________________

Applicant (19-25) status: ___ Single/Widowed/Divorced ___ Married/Common-law ___ Student

Parental Information (if applicable)

Key responsible parent, guardian or agent name: ___________________________

Address (if different from applicant): ___________________________

Telephone number (if different from applicant): Home (_____) Work (_____) ___________________________

Section 2 – Medical Criteria and Confirmation of Eligibility

Most recent A1c results:

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<thead>
<tr>
<th>Date (MM/DD/YYYY)</th>
<th>A1c</th>
<th>Date (MM/DD/YYYY)</th>
<th>A1c</th>
</tr>
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</table>

Number of DKA episodes

Last 6 months: ___________________________ Last 12 months: ___________________________

Please confirm with a checkmark (V) each of the following statements

- Regularly followed by the diabetes care team and reviewed at least 3 times per year
- Sound knowledge of how to manage diabetes including carbohydrate counting, site rotation, sick day management, etc.
- Appropriately self-monitoring of blood glucose, at least 4 times/day, recording results on paper or online and agree to continue to do so
- Able to attend a pump orientation, offered by a certified pump trainer

The child has appropriate family support (if applicable)

☐ Yes ☐ No

Client attends a diabetes care program at: ___________________________

________________________

Physician’s signature

Physician’s name (please print) ___________________________ Date ___________________________

I agree to actively attend and participate in the ongoing program for diabetes education, follow recommended guidelines insulin dosing, injection site rotation and sick day management as well as blood glucose monitoring as outlined in the treatment plan.

________________________

Applicant and/or Parent/Agent Signature

Date ___________________________
# Section 3 – Device and Supplies Requested

<table>
<thead>
<tr>
<th>Name of Applicant:</th>
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<tbody>
<tr>
<td>Medicare Number:</td>
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</table>

### Device selection

- **New pump user** - The following device and supplies are requested

<table>
<thead>
<tr>
<th>Make</th>
<th>Model and supplies</th>
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- **Existing pump user** - The following supplies are requested for the indicated device

<table>
<thead>
<tr>
<th>Make (include year client received current device)</th>
<th>Model and/or supplies</th>
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</tr>
</tbody>
</table>

- Replacement Pump
  - Required (explain):

### Notes

Diabetes Education Centre faxes Sections 1, 2, and 3 to IPP Business Office: 1-855-290-2371
New Brunswick Insulin Pump Program (IPP)
Approval Authorization Form

Client and/or Family/Guardian(s) to complete Sections 4 and 5

The client and/or family/guardian(s) will complete:

- **Section 4 – Financial Contribution Assessment**
- and
- **Section 5 – Release of Information**

Sections 4 and 5 and the requested supporting documentation will be mailed by the applicant to the IPP Business office:

NB Insulin Pump Program
Tracadie-Sheila Hospital
PO BOX 3180 - 400, rue des Hospitalières
Tracadie-Sheila, NB E1X 1G5

Please refer to the Insulin Pump Program (IPP) Policies and Procedures Manual for assistance in completing the Approval Authorization Form.

For further information or assistance call 1-855-655-5525.
New Brunswick Insulin Pump Program (IPP)
Approval Authorization Form

Section 4: Assessment of Financial Contribution

Name of Applicant: 
Date of Birth: (MM/DD/YYYY)

Applicant’s Current Mailing Address:
Medicare Number:
Applicant’s Current Telephone Number
Home 
Cell

Child (under 19) lives with: ___Mother only ___Father only ___Both parents ___Other: ____________________

Gender

Applicant (19-25) status: ___Single/Widowed/Divorced ___Married/Common-law ___Student

Parental Information (if applicable)

Key responsible parent, guardian or agent name:
Address (if different from applicant):

Telephone number (if different from applicant): Home ( ) Work ( )

Number of people living in household (children & parents within the household supported by family income):

Net family income
Household Member #1 (refer to CRA Notice of Assessment): Line 150: _____________ Line 435: _____________

Household Member #2 (refer to CRA Notice of Assessment): Line 150: _____________ Line 435: _____________

Household Member #3 (refer to CRA Notice of Assessment): Line 150: _____________ Line 435: _____________

Section 5: Release of Information

Personal and private health information is required to be released to key partners as part of the business process and continuous quality improvement, involved in the Insulin Pump Program. These partners include the NB Insulin Pump Program Business Office, the selected pump vendor identified in Section 3 and their approved subcontractor(s), the Vitalité Health Network, Horizon Health Network and the New Brunswick Department of Health. Disclosed information may include personal information found in Section 1 and personal health information about the applicant in Section 2. As well the Business Office will inform the selected vendor and their approved subcontractor(s) of the family contribution that will be required towards the purchase of the pump and supplies. The vendor and their approved subcontractor(s) will also inform the Business Office of the mailing address and tracking number of the orders when shipped and report returns or discontinuation of supplies and/or insulin pumps as well as misuse of supplies. The Medical Approval Form will be kept by the physician and the Diabetes Clinic as part of your medical record. As well, a copy will also be kept by the Business Office. The mailed in Family Contribution Assessment Form with the appropriate documentation from line 150 and line 435 on the Notices of Assessment will also be kept. These documents will be stored in a secure filing system with access limited to authorized users. Precautions are in place to ensure that this information is appropriately secure, in accordance with government and regional health authority guidelines.

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Section 5: Release of Information (Continued)

<table>
<thead>
<tr>
<th>Name of Applicant:</th>
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</thead>
<tbody>
<tr>
<td>Medicare Number:</td>
<td>Date of Birth: (MM/DD/YYYY)</td>
</tr>
</tbody>
</table>

As well, all collected information from the form, will be entered into a database that may be used within the Department of Health, to evaluate the Insulin Pump Program and to identify opportunities for improvement. In addition, the vendors and their approved subcontractors may provide Vitalité Health Network and the Department of Health with pump device and supply usage information. This data will be kept in a secure database, with access limited to appropriate users. Records with the Vitalité, Business Centre will be retained long term in accordance with the health record retention policy. The database in the Department of Health will be retained to enable long term benefit of this program in supporting the health of pump users and preventing the development of complications in accordance with the government retention policy.

I consent to Vitalité Health Network and the New Brunswick Department of Health collecting the information I provide on this form for the purpose of assessing and verifying my eligibility to receive support from the Insulin Pump Program. In addition, I consent to Vitalité Health Network and New Brunswick Department of Health collecting, using, and disclosing personal information about me disclosed on this form for the purposes as described above related to the management of the Insulin Pump Program. I also consent to Vitalité Health Network and the Department of Health receiving insulin pump and supply usage information from the selected pump vendor and their approved subcontractor(s).

All the information supplied above is true and correct to the best of my knowledge. I understand that if I choose to withhold or withdraw my consent to the collection, use, and disclosure of this information by Vitalité Health Network and New Brunswick Department of Health, I may be denied coverage under the Insulin Pump Program.

The Vendor and their approved subcontractor(s) may offer a variety of services such as access to a vendor supported website for personal health information and insulin pump data download and analysis. I understand that I use these services or resources at my own risk and the services and resources are not endorsed in whole or in part by the Government of New Brunswick, Vitalité Health Network, or the Insulin Pump Program.

If an applicant is less than 16 years of age, the legal guardian or parent may sign the form. Applicants who are 16 years of age or older should sign this consent. Applicants who are 16 years of age and older and unable to sign the form may give oral consent and the form may be signed by his/her agent. The agent acts as a witness to the declaration.

<table>
<thead>
<tr>
<th>Client name (print)</th>
<th>Signature of Client, Parent or Guardian</th>
<th>Date (MM/DD/YYYY)</th>
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</table>

Please submit Sections 4 and 5 along with appropriate Canada Revenue Agency Notice of Assessment(s) for the most recent tax year to the address below. The family income considers in addition to an independent applicant, households occupied by two or more people related by birth, common-law union, marriage, or adoption. All incomes that contribute to the family income must be reported.

For further information or assistance call 1-855-655-5525.

NB IPP - Tracadie-Sheila Hospital
PO BOX 3180 - 400, rue des Hospitalières
Tracadie-Sheila NB E1X 1G5