

New Brunswick Insulin Pump Program (NBIPP)

Confirmation of Medical Eligibility for Pump and Supplies Coverage

The information collected below will be used to determine your client's eligibility for pump and pump supplies coverage under the New Brunswick Insulin Pump Program, managed and administered by the Department of Health and Vitalité Health Network. It may be used and disclosed in accordance with other provisions of the *Personal Health Information Privacy and Access Act*.

The client is applying for:

- Pump
 Pump Supplies
 Pump and Pump Supplies

SECTION 1 - CLIENT INFORMATION

Client Name	
Legal Given Name(s)	Legal Last Name
NB Medicare #	Date of Birth
	JJ MM AAAA _____ _____ _____

SECTION 2 – DEVICE AND SUPPLIES INFORMATION

Pump and Supplies Requested
<input type="checkbox"/> New Pump User (<i>pump and supplies requested</i>) <input type="checkbox"/> Existing Pump User (<i>supplies only requested</i>) <input type="checkbox"/> Existing Pump User (<i>replacement pump and supplies requested</i>) <input type="checkbox"/> Existing Pump User (<i>replacement pump only requested</i>)
For Existing Pump User, please indicate make and model of current pump: _____
If replacement pump is required, please indicate the year client received current pump: _____
Pump Requested:
<input type="checkbox"/> Medtronic 670G <input type="checkbox"/> Omnipod Eros <input type="checkbox"/> Tandem T-Slim X2 <input type="checkbox"/> Ypsomed <input type="checkbox"/> Medtronic 770G <input type="checkbox"/> Omnipod DASH <input type="checkbox"/> Medtronic 780G
Supplies Requested:
Notes:

SECTION 3 – MEDICAL INFORMATION AND CONFIRMATION OF ELIGIBILITY

Note: Applications for pumps must be approved by a Diabetes Specialist (Endocrinologist, Internal Medicine Physician or Pediatrician).

Medical Criteria											
Most recent A1c results: _			DD	MM	YYYY	Most recent A1c results: _			DD	MM	YYYY
Number DKA Episodes:		Last 6 months:				Last 12 months:					
Please confirm with a checkmark (✓) each of the following statements:											
<input type="checkbox"/> The client is regularly followed by the diabetes care team and the care plan is reviewed at least 2 times per year. <input type="checkbox"/> The client (or parent/guardian) has sound knowledge of how to manage diabetes including carbohydrate counting, site rotation, sick day management, etc. <input type="checkbox"/> The client (or parent/guardian) is appropriately self-monitoring blood glucose, at least 4 times/day, recording results on paper or online and agrees to continue to do so. <input type="checkbox"/> The client (or parent/guardian) agrees to attend a pump orientation, offered by a certified pump trainer. <input type="checkbox"/> The client has appropriate family support (if applicable).											
Diabetes Clinic Client Attends											
Location :											
Confirmation of Eligibility											
<p>_____ has type 1 diabetes and meets the medical eligibility criteria for the New Brunswick Insulin Pump Program (NBIPP). (Client's Name)</p>											
_____ Physician's Name (please print)			_____ Physician's Signature				_____ License #		_____ Date		

If you require assistance or have questions with respect to this form, or about the collection, use, or disclosure of this information please contact NBIPP by phone toll free at 1-855-655-5525; or by email NBIPP-PPINB@gnb.ca; or visit the NBIPP website: [New Brunswick Insulin Pump Program \(IPP\) \(gnb.ca\)](http://New Brunswick Insulin Pump Program (IPP) (gnb.ca))