Optum

OB Homecare Diabetes Services – Prescription for Home Administration

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

NOTE: Copy of current **INSURANCE CARD (front & back)** must accompany submission. Initiate & manage homecare per Optum Protocols as provided for following services OR call Optum @ **800-950-3963** for other orders.

Form Completed by (Name, Title, Phone): _____

Patient Name:			Phone:
Address:		City/St./Zip:	
DOB:	Due Date:	Height:	Weight:
Preferred Language: ☐ English ☐ Other		Allergies:	
Pt. Current Location: ☐ Home ☐ Hospital (name)			
Insurance Info: (Carrier, Policy #, Phone #)			

Service Requested

Service start will occur upon verification, patient acceptance, and receipt of medication. Patient to discontinue oral antidiabetic agent at start of insulin.

☐ **Diabetes Management via Insulin Injection**

☐ Check here if patient should continue oral agent

Choose One

- ☐ OPTUM to provide/dispense Novolin R and Novolin N vials
- ☐ PATIENT to obtain insulin/medication through prescriber prescription.

☐ **Diabetes Management via Insulin Pump**

☐ Check here if patient should continue oral agent

Check all that apply

- ☐ OPTUM to provide SQ pump
- ☐ OPTUM to dispense 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

Protocol

(Choose One)

☐ Per Optum protocol – Optum to calculate initial dose and adjust ongoing insulin requirements. Prescriber will receive patient-specific information on plan of treatment after start of care.

☐ Prescriber to select here if desires 1 hr. pp 100-129 (instead of 2 hr. pp)

☐ Do not use Optum protocol – contact prescriber for initial insulin dosing and ongoing orders or attach patient specific dosing.

☐ Follow prescriber signed protocol on file with Optum. (Available for high volume providers only.)

Criteria for Service

(Check all that apply)

☐ Patient needs support and resources for tight glycemic control.

☐ Glucose out-of-range with diet and/or oral agent.

☐ Highest Blood Glucose recorded: _____

☐ Most recent A1C:
Value: _____
Date: _____

Initial Prescriber (Signature Required)

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 patient's care, and (ii) my state medical license is current and valid as indicated below.

Prescriber Signature: _____ Print Name:_____

NPI#:_____ License #:_____ State:_____ Date:_____

Practice Name:		Office Contact:
Address:		City/St./Zip:
Phone:	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 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.

Provider's Name: _____ Phone: _____

FOR INTERNAL USE ONLY	Telephone Order From:		
	RBV by Optum Nurse:	Date:	Time:
	RX Reviewed by Optum Nurse:		Date: