

# 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 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

Language of service:	
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## 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: _____	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 (        )

## Section 2 –Medical Criteria and Confirmation of Eligibility

Most recent A1c results:	Date (MM/DD/YYYY)	A1c	Date (MM/DD/YYYY)	A1c
Number of DKA episodes	Last 6 months:		Last 12 months:	
<b>Please confirm with a checkmark (v) each of the following statements</b>		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)  <input type="checkbox"/> Yes <input type="checkbox"/> No	Client attends a diabetes care program at: _____			

_____ (Applicant's name)	has type 1 diabetes and meets the medical eligibility criteria for the New Brunswick Insulin Pump Program.	
_____ 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	

## New Brunswick Insulin Pump Program (IPP) Approval Authorization Form

### Section 3 – Device and Supplies Requested

Name of Applicant:

Medicare Number:

Date of Birth: (MM/DD/YYYY)

#### Device selection

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

Make	Model and supplies

**Existing pump user** - The following supplies are requested for the indicated device

Make (include year client received current device)	Model and/or supplies

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 5: Release of Information (Continued)*

Name of Applicant:

Medicare Number:

Date of Birth: (MM/DD/YYYY)

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.

Client name (print)

Signature of Client, Parent or Guardian

Date (MM/DD/YYYY)

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**

