Saskatchewan Health
Drug Plan and Extended Benefits Branch
Saskatchewan Insulin Pump Program

Application for Funding
Saskatchewan Insulin Pump Program

3475 Albert Street
Regina, SK S4S 6X6
Phone: 1-800 667-7581 or 306 787-7121
Fax: 306 787-8679

User Identification

Surname	First Name	Initial	Health Services Number

Address	City, Town, or Village	Province	Postal Code	Birth Date (y y / m m / d d)	Phone (306)

Parent or Guardian (if applicable)	Daytime phone (306)	Evening phone (306)

Address of parent or guardian (if different than above)

Physician's Certification of Eligibility

To be completed by an endocrinologist or another specialist physician who is associated with a Regional Health Authority (RHA) diabetes program and who has experience with insulin pump management in individuals with type 1 diabetes who are 25 years of age and under.

I certify that the above named applicant:

- has Type 1 diabetes
- and meets **one or more** of the following criteria:
  1. is unable to achieve the recommended $HgbA_{1c}$ target value (i.e. 9.0% or less for children under 5 years of age; 8.0% or less for children 5 years of age or older; 7% or less for individuals 18 years of age or older) despite concerted efforts of the individual and/or family to achieve good glycemic control through strong consistency with carbohydrate intake, frequent blood glucose monitoring and a multiple daily injection regimen
  2. experiences frequent severe hypoglycemic events
  3. has marked insulin sensitivity or resistance
  4. has unpredictable large swings in blood glucose levels, with or without a Dawn phenomenon
  5. has had frequent hospitalizations for diabetic ketoacidosis not due to insulin omission **or** for attempts to improve glycemic control.

Prescriber's signature	Prescriber's name	
	Prescriber's address	
	Date	Phone number

Regional Health Authority Assessment of Eligibility

To be completed by a diabetes nurse educator associated with a Regional Health Authority (RHA) diabetes program.

Applicant has been assessed and educated by the RHA diabetes program. Yes ☐

Applicant has participated in an insulin pump information program. Yes ☐

Applicant has been advised to apply for the Saskatchewan Health Special Support Program. Yes ☐

Diabetes nurse educator's signature	Diabetes nurse educator's name	
	RHA diabetes program address	
	Date	Phone number

Equipment Requested and Specification

Selection of the brand and model of insulin pump is the applicant's responsibility. This decision should be made in consultation with the RHA diabetes program to ensure medical needs are met.

☐ **Insulin Pump <u>and</u> Supplies**

☐ **Insulin Pump Supplies <u>Only</u>**
Date of acquisition of insulin pump (if available):

_____

Insulin Pump Supplier _____

Pump Brand and Model _____

Insulin Pump Supplies
Be as specific as possible. Include brand, model, size, & manufacturer's number (if available).
_____
_____
_____

Consent and Authorization

The collection of personal health information on this form, by Saskatchewan Health, is necessary for the purposes of assessing and verifying eligibility for the Saskatchewan Insulin Pump Program, and for other purposes related to the administration of that Program.

In accordance with *The Health Information Protection Act* (Saskatchewan), and with your express consent, selected personal health information on this form may be used by or disclosed to appropriate employees of Saskatchewan Health, Regional Health Authority diabetes program(s), and the insulin pump supplier (as selected by the applicant and designated on this form). This information will only be provided on a need-to-know basis with your consent.

I consent to the collection, use and disclosure of the personal health information of _____ (Applicant's Name) for the purposes outlined above only for the period of time that _____ (Applicant's Name) is eligible for benefits under the Saskatchewan Insulin Pump Program. I understand that, if I wish to withdraw this consent, I may do so at any time by writing Saskatchewan Health, Drug Plan and Extended Health Benefits Branch at the following address:

Saskatchewan Health
Drug Plan & Extended Benefits Branch
3475 Albert Street
Regina, Saskatchewan S4S 6X6

I understand that withdrawal of consent would mean that I would no longer be eligible for benefits.

For further information on the Saskatchewan Insulin Pump Program or to discuss any concerns regarding this program or this form, please call: In Regina: 787-7121 In Saskatchewan: 1-800-667-7581

Signature: _____ ☐ Applicant ☐ Parent ☐ Agent (as appropriate)
If agent, provide evidence of authority to act on the applicant's behalf.

Print name: _____ **Date:** _____

Trial Period Evaluation (for a new pump)

Date the insulin pump was received:

I certify that the applicant has successfully completed a trial of the insulin pump.

Diabetes nurse educator's signature Date

Internal Use Only

	Initials	Date		Initials	Date
☐ SAIL Supply System updated			☐ Approval letter for new pump		
☐ EDS entered for pump supplies			☐ Special Support reassessed		
☐ SH/FHB Supplies (if applicable)					