



Welcome to the Sweet Savings Diabetes Program that is being sponsored by the Arizona Local Government Employee Benefit Trust (AZLGEBT) to help you manage your diabetes!

The Sweet Savings Diabetes Program

This program is designed to help you improve your health and save you money by teaching you how to better manage your diabetes. The success of this program is based on a collaborative effort between you, your physician, and a diabetes trained pharmacist.

During your enrollment in Sweet Savings, you will meet at regularly scheduled times with a designated pharmacist who will discuss various elements of your diabetes care including but not limited to: foot care, vision/dental care, glucose readings, medications, and vaccinations. You will be a full-fledged member of your healthcare team and will be involved in developing a treatment and education support plan that meets your individual health care needs and provides the education and skill training that you need to manage your diabetes.

Completing your enrollment in the Sweet Savings Diabetes Program

To complete the enrollment process, you need to fill out, sign, and return the next seven pages of this enrollment packet. The completed forms are to be returned to the Program Coordinator: Kristen Davison, The Pharmacist Connection, PO Box 6775, Kingman, AZ 86402, (928) 279-7206, kristen.clj@gmail.com. Please contact Kristen with any questions or concerns.



Sweet Savings Diabetes Program Sign-up Form

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____ E-mail Address (optional): _____

Street Address: _____

City: _____ State: _____ Zip code: _____ Country: _____

Phone (Home/Business/Cell): _____ Alternate Phone (optional): _____

Ethnicity: African American Asian Caucasian Hispanic Native American Other

Gender: Female Male Diabetes Type: Type 1 Type 2

Primary Language: English Spanish French Italian German Chinese Other

Highest Grade Completed: 8th Grade or Less Some College
 Some High School College Graduate
 High School Graduate Post-Graduate Education

Occupation (optional): _____ Medical Claims ID #: _____

Relationship to Employee: Self Spouse Child Other Retiree: Yes No

Physician/Primary Care (optional): _____

CONSENT TO PARTICIPATE AND RELEASE MEDICAL INFORMATION:

I am voluntarily participating in the Sweet Savings Diabetes Program, a health management program (the "Program") sponsored by my benefit plan, the Arizona Local Government Employee Benefit Trust. My participation will require that my pharmacist obtain certain medical/health information about my condition from my physician and/or other members of my health care team. By signing this form, I am giving my authorization to having information about my condition released to the pharmacist, Pharmacist Network Coordinator, The Pharmacist Connection staff and/or other health care providers participating in my care, to be used specifically and confidentially for my care and to assess quality of care and to administer the program. Further, I give my authorization that appropriately blinded/de-identified data as to my identity and condition/treatment may be aggregated with similarly blinded data from other patients enrolled in the same program for research and educational purposes. "De-identified" data means health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual in accordance with HIPAA.

I understand that I may revoke this authorization at any time upon giving written notice to Kristen Davison, The Pharmacist Connection, PO Box 6775, Kingman, AZ 86402, (928) 279-7206. Were that to be the case, I understand and agree that actions taken by any party related to the conduct of the Sweet Savings Diabetes Program during the period that relied upon my consent would stand. Also, I understand that, if this consent is not revoked, it will continue for the duration that I am enrolled in the program, and expire automatically should I discontinue my participation in the program.

I understand that I am required to sign this Authorization as a condition of my participation in the Program.

I understand that the information disclosed by this authorization may be subject to re-disclosure by the Recipients listed above and, in that case, will no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164], and the Privacy Act of 1974 [5 USC 552a].

Date: _____ Patient: _____ Signature: _____

If additional consent is required, have the authorized person sign below:

Printed Name: _____ Signature: _____ Relationship to Patient: _____



Sweet Savings Diabetes Program History of Diabetes Initial Patient Assessment

Patient Name: _____ Phone Number: _____ E-Mail Address _____

Primary Care Physician: _____ Phone Number: _____

Dietician: _____ Phone Number: _____

Date of Birth: _____ Allergies: _____

Past Medical History:

DO YOU HAVE, OR HAVE YOU EVER BEEN TOLD THAT YOU HAD (Please circle those that apply):

- Yes No Heart disease (heart attack, angina, heart surgery, arrhythmia)
- Yes No Lung disease
- Yes No High blood pressure
- Yes No Thyroid problems
- Yes No Kidney problems
- Yes No Cancer
- Yes No Liver or gallbladder trouble
- Yes No Head trauma
- Yes No Osteoporosis
- Yes No Arthritis
- Yes No Stroke or TIA
- Yes No Migraine Headaches
- Yes No Seizures
- Yes No Anxiety disorder, panic attacks
- Yes No Depression
- Yes No Glaucoma, macular degeneration or other eye problem
- Yes No Other. Describe: _____
- Yes No Serious infections. Describe: _____

Current Medications (include over-the-counter medicines and herbal remedies):

<u>DRUG</u>	<u>DOSE</u>	<u>DIRECTIONS</u>	<u>PRESCRIBING DOCTOR</u>	<u>USED FOR?</u>	<u>STARTED WHEN ?</u>
<u>1</u>					
<u>2</u>					
<u>3</u>					
<u>4</u>					
<u>5</u>					

Have you ever had any problems with your medication(s)?



History of Diabetes:

Age when diagnosed: (age/year) _____	
Hospitalization(s) or ER visits for treatment of diabetes in the last 12 months (<i>Dates/reasons/duration/outcome</i>)	Physician office visits for diabetes for the last 12 months (<i>Date/reason/outcome</i>)

Diabetes Education:

Any previous diabetes education? <input type="checkbox"/> NO <input type="checkbox"/> YES (<i>When</i>) _____ (<i>Where</i>) _____	
What is the most difficult part of having diabetes?	Do you believe your family members understand the conditions of your diabetes? <input type="checkbox"/> YES <input type="checkbox"/> NO (<i>why not?</i>)
Do you belong to any diabetes associations or support groups? <input type="checkbox"/> NO <input type="checkbox"/> YES (<i>organizations</i>)	

Exercise/Nutrition:

Current Height?	Current weight?
Have you met with a dietitian to discuss a diet plan? <input type="checkbox"/> NO <input type="checkbox"/> YES Dietitian/phone: _____	
What do your daily meals consist of?	When do you eat your meals?
What are your usual daily activities:	Do you have a regular exercise schedule? <input type="checkbox"/> NO <input type="checkbox"/> YES (<i>Type and Frequency</i>)

Lab Values (Complete if known):

MOST RECENT LAB VALUE	DATE/TIME	RESULT
Blood Glucose		
HbA1c		
Total Cholesterol		
LDL		
HDL		
TG		
Microalbumin/Urine Test		

Complete this next section only if you are currently taking insulin.



Insulin Regimens:

I am not currently taking insulin.

	BREAKFAST	LUNCH	DINNER	BEDTIME
Time				
Insulin Type				
Dosage (units)				
Number of Missed doses				
Do you administer your own insulin? If not, who administers your insulin?	Syringe size: Needle size: How do you dispose of used syringes?			
Are you having any problems with your insulin?	Describe what is meant by rotating sites?			
How do you store your insulin?	How do you carry your insulin?			

Blood Glucose Monitoring:

How do you check your blood glucose levels? <input type="checkbox"/> Do not test <input type="checkbox"/> Visual (<i>test name</i>) _____ <input type="checkbox"/> Urine test (<i>test name</i>) _____ <input type="checkbox"/> Blood Glucose Monitor (<i>meter name</i>): _____	How often do you monitor your blood sugars? (<i>Tests per day</i>)
What do you like about it? What do you dislike about it? Are you having any problems/difficulties with the meter? (<i>Describe</i>)	
Based on the results you get from your meter, what do you consider to be high, normal, and low sugar values? HIGH: _____ NORMAL: _____ LOW: _____	

Hypoglycemia Awareness:

Have you ever experience low blood sugars? <input type="checkbox"/> NO <input type="checkbox"/> YES (<i>date of last episode</i>): _____ (<i>How often does this occur?</i>): _____	Which of these symptoms have you experienced? <input type="checkbox"/> Shakiness/trembling <input type="checkbox"/> Drowsiness/weakness <input type="checkbox"/> Tiredness <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Confusion/Disorientation <input type="checkbox"/> Faintness or fainted <input type="checkbox"/> Hunger <input type="checkbox"/> Increase heart rate <input type="checkbox"/> Irritability <input type="checkbox"/> Sweating
How do you usually treat this?	



Self Care:

Foot Care

How often do you inspect your feet?	Are you having any problems with your feet?
Do you see a podiatrist for foot care? <input type="checkbox"/> NO <input type="checkbox"/> YES (Doctor's name/phone): _____	

Dental/Vision

Date of last dentist visit: _____	Date of last eye exam: _____
Dentist name/phone number: _____	Ophthalmologist name/phone number: _____

Please check any symptoms you have experienced in the last 6 months and explain.

Symptoms:

<input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Diarrhea <input type="checkbox"/> Nausea <input type="checkbox"/> Anorexia <input type="checkbox"/> Dribbling <input type="checkbox"/> Overflow Incontinence <input type="checkbox"/> Impotence <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Profuse Sweating <input type="checkbox"/> Heat Intolerance	<input type="checkbox"/> Decreased Heat and Light Touch Sensation <input type="checkbox"/> Burning <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Intense Pain <input type="checkbox"/> Diminished Sense of Touch, Vibration, and <input type="checkbox"/> Temperature <input type="checkbox"/> Orthostatic Hypotension (light headedness, pain in the neck, or visual changes) <input type="checkbox"/> Loss of Consciousness
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Sick Day Care:

How do you take care of your Diabetes when you are ill?	How often do you miss doses of your medication while you are sick?
How often do you monitor your blood sugar when you are ill?	How often do you check your urine for ketones?



Sweet Savings Diabetes Program **Consent to Participate Form**

By completing this form, you acknowledge that you have been fully informed about the program, including:

1. Your right to confidentiality

In order to assure the confidentiality of the information you provide, a computer generated identification (ID) code will be used to identify you and data resulting from your participation in the program. Further, coded information and data will only be shared with those parties who have a need to know and for whom you give authorization to have access. Parties who will need to have access are trusted health professionals who provide care, pharmacy benefit managers who handle claim forms, and data processing personnel who will aggregate coded data about you and your progress with similarly coded data collected from other patients participating in the same program. Aggregated data will be used to evaluate the overall success of the Sweet Savings Diabetes Program. Your name will not be associated with any published results.

2. Waived Co-Pays

As a participant in the program, the co-pays that you are now required to make when purchasing your diabetes medications and related supplies will be waived during your active participation in the program if you are enrolled in the PPO medical benefit plan; if you are enrolled in the high deductible health plan, you may still benefit from pharmacist visits, but you will be responsible for all costs associated with your prescriptions and testing supplies. To be an active participant, you must complete laboratory tests and attend pharmacist visits as stated herein. Your co-pays will start being waived AFTER you've completed your initial visit with the pharmacist **AND** provided him/her with clinical values (Glucose, A1C, Cholesterol, HDL, LDL, and Triglycerides) that have been obtained within the past six months. If you do not have current lab values, you are encouraged to meet with your physician and/or participate in a blood draw through your wellness program if applicable.

3. Clinical measurements and laboratory tests

To assure that your diabetes is controlled, at regular intervals your physician and pharmacist will conduct certain clinical measurements and laboratory tests including but not limited to: Weight, Glucose, A1C, Cholesterol, HDL, LDL, Blood Pressure, and Triglycerides. These clinical values must be obtained by and/or provided to the pharmacist annually (at minimum) to remain in the program. Please include a copy of your current laboratory values with this enrollment packet or bring them to your initial pharmacist visit.

4. Risks, inconveniences, and discomforts

As is the case with all health care programs, you are reminded that there are potential risks associated with the treatment of any disease. Specific risks associated with your diabetes care will be discussed with you as appropriate. Further, because of the time pressure that health care providers work under these days, you may have to arrange your schedule to accommodate that of the health care team. In this regard, it will be expected that you will make every effort to do so (see section on Cancellations and Missed Appointments). Lastly, medical care does have its discomforts. For instance, not too many people look forward to having blood drawn for a laboratory test. You should discuss your individual concerns with your health care team.

5. Patient Self-Management Credential for Diabetes

As you participate in this program, you will become more knowledgeable about your disease and its treatment. The program is designed to initially assess how much you know about diabetes and its proper care. The results of this initial assessment will provide information that the health care team will use to tailor a specific program to fill in the educational and training gaps so indicated. As you progress through this educational/training component of the program, you will receive continuous support from the health care team. Upon successful completion of a final assessment of (a) your knowledge of diabetes, (b) your skills at self-managing your condition, and (c) your performance as indicated by your record of maintaining good control of your diabetes, you will receive the Patient Self-Management Credential for Diabetes.

6. Right to withdraw

Since you volunteered to participate in the program, you have the right to withdraw at any time. In the event you find that you are not able to participate in the Program, for whatever reason, you should immediately notify the Program Coordinator. There will be no penalties; however your co-pays will be reinstated.



7. Authorization to request medical information

Giving permission to enable your pharmacist to obtain confidential information about your diabetes from your physician, or other diabetes health care specialist whom you may be seeing, is important to assure the continuity of your diabetes care.

8. Enrolling

Once you've returned your completed enrollment packet to the Program Coordinator, he/she will send a copy to the program pharmacist in your area. Your pharmacist is to contact you within one week after receiving notification of your enrollment. If you are not contacted by the pharmacist within one week, you should notify the Program Coordinator. When your pharmacist calls you, you are to schedule the time for your initial visit.

9. What to expect in the initial visit

Please bring a copy of your current lab values to your initial visit if you have not included them with your enrollment packet. During your initial visit, the pharmacist will review the Sweet Savings Diabetes Program with you and answer your questions. Also, it is at this time that you will be asked to complete a brief set of questions that will provide the health care team an initial assessment of your knowledge of diabetes and its treatment. As indicated above, the results of this initial assessment will be used to develop an overall care plan that will state the specific educational and skill training goals set by the pharmacist. The plan will include:

- A schedule of follow up visits at which times the pharmacist will provide indicated counseling, education and skill training;
- A schedule of laboratory measurements for Hemoglobin A1C, blood glucose, and lipids;
- Life style changes desired; and
- A plan for monitoring kidney, nerve and eye conditions

During the first 3 months of the program, you will meet with your pharmacist a minimum of once per month. Thereafter, you and your pharmacist will determine the frequency of visits; however it will be at least once each quarter.

9. Appointment Scheduling

Except in an emergency situation, you must give 24-hour notice if you are unable to keep a scheduled appointment with the pharmacist; in the case of an emergency situation, you should notify your pharmacist as soon as possible. In those instances when the pharmacist may need to schedule, or re-schedule, an appointment with you, the pharmacist will immediately contact you. If you are not available, the pharmacist will leave a message for you; it is very important that you respond to any message promptly. If you do not meet with your pharmacist at least once every three months, you will receive a letter notifying you that you will be dropped from the program and your co-pays will be reinstated. The pharmacist should contact you to schedule appointments; however, it is ultimately your responsibility to schedule appointments appropriately to avoid being dropped from the program. If your pharmacist is not contacting you or you have other concerns, please don't hesitate to contact the Program Coordinator.

PPO Medical Benefit Plan Participants

I, _____, understand what will be required of me to become and remain an active participant in the Sweet Savings Diabetes Program. I agree to follow the stated policies and procedures as stated in this document and understand that my failure to do so may result in my being dropped from the program. I understand that if I do not provide my pharmacist with updated laboratory values annually and/or if I do not meet with the pharmacist at least once every three months, I will be dropped from the program and my co-pays will be reinstated.

Participant Signature _____ Date _____
(Or Parent /Guardian)

High Deductible Medical Benefit Plan Participants

I, _____, understand what will be required of me to become and remain an active participant in the Sweet Savings Diabetes Program. I agree to follow the stated policies and procedures as stated in this document and understand that my failure to do so may result in my being dropped from the program. If I do not provide my pharmacist with updated laboratory values annually and/or if I do not meet with the pharmacist at least once every three months, I will be dropped from the program. I understand that due to federal regulations, my co-pays will not be waived as an incentive for program participation but I would still like to benefit from the education and pharmacist visits.

Participant Signature _____ Date _____
(Or Parent /Guardian)
Coordinator's Signature _____ Date _____