

Omnipod 5 Insulin Delivery System Prior Authorization Request Form

Caterpillar Prescription Drug Benefit
Phone: 877-228-7909 Fax: 800-424-7640

MEMBER'S LAST NAME: _____ MEMBER'S FIRST NAME: _____

Instructions: Please fill out all applicable sections completely and legibly. Attach any additional documentation that is important for the review (e.g., chart notes or lab data, to support the authorization request). Information contained in this form is Protected Health Information under HIPAA.

URGENT

MEMBER INFORMATION		
LAST NAME:	FIRST NAME:	
PHONE NUMBER:	DATE OF BIRTH:	
STREET ADDRESS:		
CITY:	STATE:	ZIP CODE:
PATIENT INSURANCE ID NUMBER:		

MALE FEMALE HEIGHT (IN/CM): _____ WEIGHT (LB/KG): _____ ALLERGIES: _____

IF YOU ARE NOT THE PATIENT OR THE PRESCRIBER, YOU WILL NEED TO SUBMIT A PHI DISCLOSURE AUTHORIZATION FORM WITH THIS REQUEST WHICH CAN BE FOUND AT THE FOLLOWING LINK: PRIMETHERAPEUTICS.COM/NOPP

PATIENT'S AUTHORIZED REPRESENTATIVE (IF APPLICABLE): _____
AUTHORIZED REPRESENTATIVE'S PHONE NUMBER: _____

PRESCRIBER INFORMATION			
LAST NAME:	FIRST NAME:		
PRESCRIBER SPECIALTY:	EMAIL ADDRESS:		
NPI NUMBER:	DEA NUMBER:		
PHONE NUMBER:	FAX NUMBER:		
STREET ADDRESS:			
CITY:	STATE:	ZIP CODE:	
REQUESTER (if different than prescriber):	OFFICE CONTACT PERSON:		

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	FREQUENCY:	LENGTH OF THERAPY/REFILLS:	QUANTITY:
<input type="checkbox"/> NEW THERAPY	<input type="checkbox"/> RENEWAL	IF RENEWAL: DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

Continued on next page

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1. HAS THE PATIENT TRIED ANY OTHER MEDICATIONS FOR THIS CONDITION?

YES (if yes, complete below) NO

MEDICATION/THERAPY (SPECIFY DRUG NAME AND DOSAGE):	DURATION OF THERAPY (SPECIFY DATES):	RESPONSE/REASON FOR FAILURE/ALLERGY:

2. LIST DIAGNOSES:

ICD-10:

Type 1 diabetes
 Other diagnosis: _____ ICD-10 Code(s):

3. REQUIRED CLINICAL INFORMATION: PLEASE PROVIDE ALL RELEVANT CLINICAL INFORMATION TO SUPPORT A PRIOR AUTHORIZATION.

Will the patient be using the drug as a part of the clinical trial? Yes No

Does patient have Type I diabetes? Yes No

Is prescriber an endocrinologist or is in consultation with an endocrinologist? Yes No

Initial Request for Omnipod 5 AND ALSO on an Insulin Pump:

Is patient a New Start to the Omnipod 5, but is currently on another insulin pump device?

Yes No

Does patient continue to have at least 2 of the following while on an insulin pump device?

Yes No

- HbA1c greater than 7% within the last 6 months
- Patient has continual, recurring hyperglycemia [BG>200mg/dL] greater than two times per week
- Patient has continual, recurring hypoglycemia [BG < 70 mg/dL] at least one time per week which required additional glucose intervention
- Patient is unaware of hypoglycemia episodes
- Repeated episodes of diabetic ketoacidosis
- Patient experiences Dawn Phenomena where glucose level exceeds 200mg/dl more than two times per week

Does the patient have an absolute contraindication to another non-disposable insulin delivery pump such as the Tandem TSlim, which makes the patient require a closed-loop disposable insulin delivery system like the Omnipod 5? Yes No Please provide detailed rationale.

Has patient received their Dexcom G6, G7 or other compatible continuous glucose monitor(CGM) from their medical provider OR has been instructed that the compatible continuous glucose monitor(CGM) must be obtained by their medical provider? Yes No

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Does patient require a quantity of over #10 pods / 30 days? Yes No Please submit how much insulin the patient uses per month to justify a quantity limit override _____

Initial Request for Omnipod 5, NOT currently on an insulin pump:

Is patient a new start to the Omnipod 5 disposable insulin delivery system? Yes No

Has patient completed a diabetes education program? Yes No

Has patient been on a maintenance program for at least 6 months involving at least THREE injections of insulin per day and frequent self-adjustments of insulin dosage? Yes No

Has patient (or someone assisting member) performed glucose self-testing at least FOUR times per day on average during the preceding month? Yes No

Is patient at high-risk for preventable complications of diabetes such as hypo/hyperglycemia, diabetic ketoacidosis, neuropathies, kidney disease? Yes No

Is patient (or someone assisting member) capable of managing the pump system? Yes No

Does the patient have an absolute contraindication to another non-disposable insulin delivery pump such as the Tandem TSlim, which makes the patient require a closed-loop disposable insulin delivery system like the Omnipod 5? Yes No Please provide detailed rationale.

Has the patient been on a program of intensive treatment that has failed to control blood sugars as evidenced by one or more of the following? Yes No (note all that apply):

- HbA1c greater than 7% within the last 6 months
- History of recurring hypoglycemia [BG < 70 mg/dL]
- Wide fluctuations in blood glucose before mealtime
- A marked early morning increase in fasting blood sugar (Dawn Phenomenon – glucose level exceeds 200mg/dl)
- Repeated episodes of diabetic ketoacidosis
- History of severe glycemic excursions

Has patient received their Dexcom G6, G7 or other compatible continuous glucose monitor(CGM) from their medical provider OR has been instructed that the compatible continuous glucose monitor(CGM) must be obtained by their medical provider? Yes No

Does patient require a quantity of over #10 pods / 30 days? Yes No Please submit how much insulin the patient uses per month to justify a quantity limit override _____

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Renewal Criteria:

Is patient new to the plan and a Type I or Type II diabetic currently utilizing the Omnipod 5 disposable insulin delivery system? Yes No

Is patient continuing to have evidence of improvement in their control of their diabetes, since initial use of the Omnipod 5? Yes No Please provide documentation.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: Not all drugs/diagnosis are covered on all plans. This request may be denied unless all required information is received.

ATTESTATION: I attest the information provided is true and accurate to the best of my knowledge. I understand that the Health Plan, insurer, Medical Group or its designees may perform a routine audit and request the medical information necessary to verify the accuracy of the information reported on this form.

Prescriber Signature or Electronic I.D. Verification: _____ **Date:** _____

CONFIDENTIALITY NOTICE: The documents accompanying this transmission contain confidential health information that is legally privileged. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately (via return FAX) and arrange for the return or destruction of these documents.

FAX THIS FORM TO: 800-424-7640

MAIL REQUESTS TO: Prime Therapeutics Management Prior Authorization Program

Attn: CP-4201

P.O. Box 64811

St. Paul, MN 55164-0811

Phone: 877-228-7909