Omnipod 5

Member and Medication Information * indicates required field	
*Member ID:	*Member Name:
*DOB:	*Weight:
*Medication Name/ Strength:	
☐ Do Not Substitute. Authorizations will be processed for the preferred Generic/Brand equivalent unless specified.	
*Directions for use:	
Provider Information * indicates required field	
*Requesting Provider Name:	*Requesting Prescriber NPI:
Address:	
*Contact Person:	*Office Phone:
*Office Fax:	*Office Email:
Fax form and relevant documentation including: laboratory results, chart notes and/or updated provider letter to Pharmacy PA at **855-828-4992**, to prevent processing delays.	

***Other insulin pumps are available under the Durable Medical Equipment (DME) benefit**

Criteria for Approval: *(ALL of the following criteria must be met)*

1. Is the disposable insulin pump system being prescribed by an endocrinologist or in consultation with a provider specializing in the treatment of diabetes mellitus? ❑ **Yes** ❑ **No**
   - ☐ For infusion of at least 5 units of insulin per day
   - ☐ Insulin total daily dose: _____
2. Does the patient and/or caregiver adhere to a comprehensive diabetes treatment plan supervised by the treating provider and can they recognize and respond to the messages, alarms and alerts of the device? ❑ **Yes** ❑ **No**
3. Does the provider attest that the patient is **NOT** pregnant, on dialysis, or critically ill? ❑ **Yes** ❑ **No**
4. Does the provider attest that the patient and/or caregiver has received (or will receive) appropriate ongoing counseling and training for Omnipod use? ❑ **Yes** ❑ **No**
5. Will Omnipod 5 be used in conjunction with a compatible and UT Medicaid-preferred continuous glucose monitor or will be testing blood glucose levels accordingly? ❑ **Yes** ❑ **No**
6. Does the provider attest that the patient has **NOT** been approved for another non-disposable insulin pump other than Omnipod within the last 5 years? ❑ **Yes** ❑ **No**

   If **NO**, provide following details:

   Pump details: _____ Date Received: _____

   Reason to request Omnipod:_____

Additional criteria for Approval for Type 1 diabetes: *(ALL of the following criteria must be met)*

7. Is the patient 2 years of age or older? ❑ **Yes** ❑ **No**

Additional criteria for Approval for Type 2 diabetes: *(ALL of the following criteria must be met)*

8. Is the patient 18 years of age or older? ❑ **Yes** ❑ **No**

9. Does the member meet **ONE** of the following criteria? ❑ **Yes** ❑ **No**
   - ☐ The patient requires ≥ 3 insulin injections per day and has a hemoglobin A1c% of at least 7%? **AND** the patient requires ≥ 4 blood glucose tests daily, or is utilizing a continuous glucose monitor (CGM) **OR**
   - ☐ The patient has a history of hypoglycemia with dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl, hypoglycemic unawareness, or nocturnal hypoglycemia **OR**
   - ☐ The patient has a loss of manual dexterity

Re-authorization Criteria:

1. Has the provider submitted an updated letter with medical justification or updated chart notes demonstrating positive clinical response? Chart note page #: _____ ❑ **Yes** ❑ **No**

Initial Authorization: Up to one (1) year
Re-authorization: Up to one (1) year

PROVIDER CERTIFICATION

I hereby certify this treatment is indicated, necessary and meets the guidelines for use.

_____ _____

Prescriber's Signature Date