Omnipod 5 disposable insulin del sys
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: HTTPS://MAGELLANRX.COM/MEMBER/EXTERNAL/COMMERCIAL/COMMON/DOC/EN-US/PHI_DISCLOSURE_AUTHORIZATION.PDF

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:**
REQUESTOR (if different than prescriber)**:**	**OFFICE CONTACT PERSON:**

MEDICATION OR MEDICAL DISPENSING INFORMATION			
MEDICATION NAME:			
DOSE/STRENGTH:	**FREQUENCY:**	**LENGTH OF THERAPY/REFILLS:**	**QUANTITY:**
☐ **NEW THERAPY** ☐ **RENEWAL**		**IF RENEWAL:** DATE THERAPY INITIATED:	
DURATION OF THERAPY (SPECIFIC DATES):			

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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 I Diabetic ☐ Other diagnosis: _____ICD-10_____	

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

Clinical Information:
Is the drug going to be used in conjunction with a 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

<u>Initial Request for Omnipod 5 AND ALSO on an Insulin Pump</u>:
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

Why does the patient require a closed-loop disposable insulin delivery system like the Omnipod 5 versus other non-disposable insulin delivery pumps such as the TandemTslim? <u>Please provide detailed rationale</u>.

Has patient received their Dexcom G6 continuous glucose monitor(CGM) from their medical provider OR has been instructed that the Dexcom G6 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_____

<u>Initial Request for Omnipod 5, NOT currently on an insulin pump:</u>
Is patient a new start to the <u>Omnipod 5</u> disposable insulin delivery system? ☐ Yes ☐ No
Has patient completed a diabetes education program? ☐ Yes ☐ No

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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

Why does the patient require a closed-loop disposable insulin delivery system like the Omnipod 5 versus other non-disposable insulin delivery pumps such as the TandemTslim? 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 continuous glucose monitor(CGM) from their medical provider OR has been instructed that the Dexcom G6 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_____

Renewal Criteria:
Is patient 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/diagnoses are covered on all plans. This request may be denied unless all required information is received.

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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:** _____

FAX THIS FORM TO: 800-424-7640
MAIL REQUESTS TO: Magellan Rx Management Prior Authorization Program
Attn: CP-4201
P.O. Box 64811
St. Paul, MN 55164-0811
Phone: 877-228-7909

Magellan Rx Management – Commercial Clients.
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