Omnipod® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY HAVE BARCODES.

This form may be faxed to 844-403-1029.

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	ZIP:	Office Street Address:		
Phone:			City:	State:	ZIP:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
	Directions for Use:	

Clinical Information (required)

1. Does the patient have a diagnosis of diabetes?	❑ Yes ❑ No
2. Has the patient completed a comprehensive diabetic education program?	❑ Yes ❑ No
3. Has the patient been on a program of multiple daily injections of insulin (i.e., at least 3 injections per day), with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump?	❑ Yes ❑ No
4. Does the patient have a documented frequency of glucose self-testing an average of at least 4 times per day during the 2 months prior to initiation of the insulin pump?	❑ Yes ❑ No
5. 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? *(If yes, check which applies)* ❑ Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl ❑ Hemoglobin A1C greater than 7.0 % ❑ History of severe glycemic excursions ❑ History of severe hypoglycemia or ketoacidosis ❑ Multiple insulin injections per day (3 or more) ❑ Multiple physician office visits ❑ Wide fluctuations of blood sugars before mealtimes (e.g., pre-prandial blood glucose level commonly exceed 140 mg/dl)	❑ Yes ❑ No
6. Has the patient been on a pump prior to enrollment with the current plan and has documented frequency of glucose self-testing an average of at least 4 times per day during the month prior to enrollment with the current plan?	❑ Yes ❑ No
7. Is the patient requesting Omnipod for pre-conception or pregnancy to reduce the incidence of fetal mortality or anomaly?	❑ Yes ❑ No

Information on this form is accurate as of this date.

Prescriber's Signature:	**Date:**

Omnipod® Prior Authorization Request Form (Page 2 of 2)

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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: **This request may be denied unless all required information is received.**
For more information about the prior authorization process, please contact us at 855-811-2218.
Monday – Friday: 8 a.m. to 1 a.m. Eastern, and Saturday: 9 a.m. to 6 p.m. Eastern

OptumRx has partnered with CoverMyMeds to receive prior authorization requests, **saving you time and often delivering real-time determinations.**
Visit go.covermymeds.com/OptumRx to begin using this free service.