Omnipod Prior Authorization Form

WEST VIRGINIA DEPARTMENT OF HUMAN SERVICES

West Virginia Medicaid
Bureau for Medical Services

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (MI)

Prescriber Address (Street) | (City) | (State) | (Zip)

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Product (Select one)

- ☐ Omnipod Dash
- ☐ Omnipod 5 G6/G7
- ☐ Omnipod 5 G6/Libre 2 Plus
- ☐ Other (Please specify) _____

Diagnosis | ICD Diagnosis Code (if available)

What is the name of the insulin that will be used in the Omnipod pods?

How often will the patient be instructed to change/replace each Omnipod pod?

How many units of insulin per day will be used in the Omnipod pods?

Most Recent Hemoglobin A1C:

Date of Most Recent A1C:

Other Pertinent Information

If this is the initial authorization request for Omnipod, please also complete the section below:

Initial Authorization

Will the initial dispensing be for an Omnipod Intro Kit ? ☐ Yes ☐ No

What medication(s) was the patient utilizing to treat this condition immediately before the decision was made to change to an Omnipod system? (Please include the entire current regimen, attach additional pages as necessary)

Medication Name	Strength	Directions for Use (including dose and dosing frequency)	Start Date

Has the patient received diabetic education? ☐ Yes ☐ No - Not Approved

Is the patient currently self-testing his/her blood glucose? ☐ Yes - **Attach glucose logs from the last 90 days (required)** ☐ No - Not Approved

Indicate if any of the following apply to this patient (Check all that apply):

- ☐ Documented history of recurring hypoglycemia
- ☐ Wide fluctuations in pre-meal glucose
- ☐ History of severe glycemic excursions
- ☐ Experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200mg/dL
- ☐ Current use of an insulin pump (in the last 30 days)

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature _____ Date: (MM/DD/YYYY) _____