

# Omnipod Prior Authorization Form



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)
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Prescriber Name (Last)	(First)	(MI)
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Prescriber Address (Street)	(City)	(State)	(Zip)
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Prescriber 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
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Pharmacy Name (if applicable)
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Pharmacy Address (Street)	(City)	(State)	(Zip)
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Pharmacy 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
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**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.

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Product (Select one)	Diagnosis	ICD Diagnosis Code (if available)
Omnipod Dash		
Omnipod 5 G6/G7		
Omnipod 5 G6/Libre 2 Plus		
Other (Please specify)		

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

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Most Recent Hemoglobin A1C:	Date of Most Recent A1C:
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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
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Has the patient received diabetic education?		Yes	No - Not Approved
Is the patient currently self-testing his/her blood glucose?		Yes - <b>Attach glucose logs from the last 90 days (required)</b>	No - Not Approved
Indicate if any of the following apply to this patient (Check all that apply):			
<input type="checkbox"/> Documented history of recurring hypoglycemia <input type="checkbox"/> Wide fluctuations in pre-meal glucose <input type="checkbox"/> History of severe glycemic excursions <input type="checkbox"/> Experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200mg/dL <input type="checkbox"/> 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)