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:	ity: State: ZIP		ZIP:		
Medication Information (required)							
Medication Name:			Strength: Dosage Form:		n:		
			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?						er 🛛 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? (<i>If yes, check which applies</i>) 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:

This document - and others if attached - contains information that is privileged, confidential and/or may contain protected health information (PHI). The provider named above is required by applicable law to safeguard PHI. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. If you are not the intended recipient, please notify the sender immediately. Office use only: Omnipod_BCBSSC_2020May

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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?

<u>Please note</u>: **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 <u>go.covermymeds.com/OptumRx</u> to begin using this free service.

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