PRIOR AUTHORIZATION REQUEST

Omnipod

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll-free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A: Please note that supporting clinical documentation is required for **ALL** PA requests.

1	Is the request an INITIAL or CONTINUATION of therapy? [] Initial (If checked, go to 2) [] Continuation (If checked, go to 6)		
2	Has the patient completed a comprehensive diabetes and self-management educational program? [If no, no further questions.]	Yes	No

If you have any questions, call:
1-888-258-8250

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3	Does the patient have a documented frequency of blood-glucose testing at least 4 times per day for at least two months prior to requesting an external insulin pump? ACTION REQUIRED: Submit supporting documentation. [If no, no further questions.]	Yes	No
4	Is the patient currently managing their insulin therapy with at least 3 injections per day for at least six months prior to requesting an external insulin pump? [If no, no further questions.]	Yes	No
5	Has the patient experienced at least ONE of the following during the last six months using their multiple daily insulin injection protocol? [] Severe glycemic events (If checked, no further questions) [] Wide fluctuations in blood glucose before or after mealtime (If checked, no further questions) [] Dawn phenomenon with fasting blood sugars greater than or equal to 200 mg/dL (If checked, no further questions) [] History of recurrent hypoglycemia (blood glucose less than 70 mg/dL) (If checked, no further questions) [] Glycosylated hemoglobin level (HbA1c) greater than 7% (If checked, no further questions) [] Other (If checked, no further questions)		
6	Has documentation been submitted to confirm that the patient has been evaluated and had a clinically significant response to therapy for at least 3 months, as determined by the provider? ACTION REQUIRED: Submit supporting documentation.	Yes	No

Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

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maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

FAX COMPLETED FORM TO: 1-833-896-0656

Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

If you have any questions, call: 1-888-258-8250