US Family Health Plan

Prior Authorization Request Form for

Omnipod 5 Kits and Pods

To be completed and signed by the prescriber. To be used only for prescriptions which are to be filled through the Department of Defense (DoD) US Family Health Plan Pharmacy Program. US Family Health Plan is a TRICARE contractor for DoD.

The completed form may be faxed to 855-273-5735

OR

The patient may attach the completed form to the prescription and **mail** it to:
Attn: Pharmacy, 77 Warren St, Brighton, MA 02135

QUESTIONS? **Call 1-877-880-7007**

Clinical documentation may be required for approval.

Initial and renewal prior authorization expires after 1 year. For renewal of therapy an initial prior authorization is required.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. Is the requested medication being used for diabetes?	☐ Yes proceed to question **2**	☐ No **STOP** **Coverage not approved**
2. Provider acknowledges that a current PA approval for Omnipod 3 or Omnipod 4 does not grant automatic approval for Omnipod 5. A new PA is required for Omnipod 5.	☐ Acknowledged Proceed to question **3**	
3. Has the patient received this product under the TRICARE PHARMACY benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested product.*	☐ Yes (prior use will be verified) Proceed to question **4**	☐ No Proceed to question **6**
4. Has the patient been successful with therapy as shown by increased time in range (TIR) or improved A1c?	☐ Yes **Sign and date below**	☐ No Proceed to question **5**
5. Has the patient experienced a decrease in hypoglycemic episodes?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
6. Is Omnipod 5 prescribed by or in consultation with an endocrinologist?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Does the patient have a documented diagnosis of Type 1 diabetes mellitus?	☐ Yes proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. Has the patient completed a comprehensive diabetes education program (to include teaching patient and caregiver how to administer insulin via syringe)?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient demonstrated willingness and ability to play an active role in diabetes self-management?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3

I certify the above is true to the best of my knowledge. Please sign and date:

Prescriber Signature _____ Date _____