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**

Initial and renewal prior authorization expires after 1 year. For renewal of therapy an initial USFHP prior authorization approval is required. Medical documentation must be attached. Failure to provide could result in denial.

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. 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 **2**	
2. Has the patient received this product under the USFHP PHARMACY benefit in the last 6 months? *Please choose "No" if the patient did not previously have a USFHP approved PA for the requested product.*	☐ Yes (prior use will be verified) Proceed to question **3**	☐ No Proceed to question **5**
3. 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 **4**
4. Has the patient experienced a decrease in hypoglycemic episodes?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Is Omnipod 5 prescribed by or in consultation with an endocrinologist?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a documented diagnosis of Type 1 diabetes mellitus?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Is the patient on an insulin regimen of 3 or more injections per day using both basal and prandial insulin and has failed to achieve glycemic control after six months of Multiple Daily Injection (MDI) therapy?	☐ Yes proceed to question **9**	☐ No proceed to question **8**
8. Is the patient utilizing another insulin-pump device and is switching to Omnipod 5?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient completed a comprehensive diabetes education program?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. 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