US Family Health Plan

Prior Authorization Request Form for

# Omnipod and Omnipod DASH

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.

## 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<br>proceed to question **2** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **2. Has the patient received this medication under the TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Omnipod, Omnipod DASH.* | ☐ Yes<br>(subject to verification)<br>Proceed to question **3** | ☐ No<br>Proceed to question **4** |
| **3. Has the patient been successful with therapy?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **4. Does the patient have diabetes mellitus?** | ☐ Yes<br>Proceed to question **5** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **5. Does the patient require insulin therapy?** | ☐ Yes<br>Proceed to question **6** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **6. Does the patient have a documented diagnosis of Type 1 diabetes mellitus (DM)?** | ☐ Yes<br>Proceed to question **8** | ☐ No<br>Proceed to question **7** |

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| | | |
|---|---|---|
| **7. Is the patient on an insulin regimen of 3 or more injections per day and has failed to achieve glycemic control after six months of Multiple Daily Injection (MDI) therapy?** | ☐ Yes<br>Proceed to question **8** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **8. Does the patient perform 4 or more blood glucose tests per day or is using a Continuous Glucose Monitoring (CGM) system?** | ☐ Yes<br>Proceed to question **9** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **9. Has the patient completed a comprehensive diabetes education program (to include teaching patient and caregiver how to administer insulin via syringe)?** | ☐ Yes<br>Proceed to question **10** | ☐ No<br>**STOP**<br>**Coverage not approved** |
| **10. Has the patient demonstrated willingness and ability to play an active role in diabetes self-management?** | ☐ Yes<br>**Sign and date below** | ☐ No<br>**STOP**<br>**Coverage not approved** |

**Step 3**

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

_____ _____

Prescriber Signature Date