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**

Initial and renewal prior authorization expires after 1 year. For renewal of therapy an initial USFHP prior authorization approval 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. Has the patient received this medication under the USFHP 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 (subject to verification) Proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient been successful with therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Does the patient have diabetes mellitus?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient require insulin therapy?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. 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 Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient perform 4 or more blood glucose tests per day or is using a Continuous Glucose Monitoring (CGM) system?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Has the patient completed a comprehensive diabetes education program?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. 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 _____

[18 May 2022]