HEALTH PLANS
UNIVERSITY OF UTAH

PRIOR AUTHORIZATION REQUEST FORM
OMNIPOD DASH®

For authorization, please answer each question and fax this form PLUS chart notes back to the U of U Health Plans Prior Authorization Department at 888-509-8142.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call for assistance: Healthy U: 855-856-5694, University of Utah Health Employees: 855-856-5690, Individual & Family Plans : 855-869-4769, Commercial Groups: 855-859-4892, MHC 855-885-7695

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

Date:	Member Name:	ID#:
DOB:	Gender:	Physician:
Office Phone:	Office Fax:	Office Contact:
Height/Weight:		

Member must try formulary preferred drugs before a request for a non-preferred drug may be considered. If treatment with preferred products has not been successful, you must submit which preferred products have been tried, dates of treatment, and reason for failure. Reasons for failure must meet the Health Plan medical necessity criteria.

Product being requested: ☐ Omnipod DASH®

Dosing/Frequency:____

If the request is for reauthorization, proceed to reauthorization section.

Questions	Yes	No	Comments/Notes
TYPE 1 DIABETES, DIABETES DURING PREGNANCY, GESTATIONAL DIABETES			
1. Does the member have a diagnosis of Type 1 diabetes, diabetes during pregnancy, or gestational diabetes?	☐	☐	**Please provide documentation**
TYPE 2 DIABETES			
2. Does the member have a diagnosis of Type 2 diabetes?	☐	☐	**Please provide documentation**
3. Is the request made by a treating endocrinologist or diabetes specialist?	☐	☐	
4. Has the member had at least 1 year of subcutaneous multidose insulin therapy?	☐	☐	**Please provide documentation**
5. Has the member injected 3 or more injections of insulin per day, including long-acting insulin analogs plus a short-acting insulin analog, for at least 2 months prior to initiation of insulin pump as shown by log books?	☐	☐	**Please provide documentation**
6. Has the member self-tested glucose at least 4 times per day for 2 months prior to initiation of the insulin pump as shown by log books?	☐	☐	**Please provide documentation**
7. Does documentation show the member or member's caregiver(s) is able to perform carbohydrate counting and insulin dose calculations?	☐	☐	**Please provide documentation**

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8. Does documentation include the diabetes specialist's assessment of clinical therapeutic value of an insulin pump and ability to train member on appropriate use of insulin pump?	☐	☐	**Please provide documentation**
9. Does documentation show at least 2 visits with a diabetes specialist during the six months prior to initiation?	☐	☐	**Please provide documentation**
1. Does the member meet one or more of the following criteria while on a multiple daily injection insulin? • Glycosylated hemoglobin levels (HbA1c) greater than 8%. • Recent history (within the last six months) of significant, recurring hypoglycemia (less than 60mg/dL or requiring assistance). • Wide fluctuations (well above and below set glycemic targets) in blood glucose before and after meal times, despite appropriate adjustment of doses. • At least one documented incidence of hyperglycemic hyperosmotic syndrome or diabetic ketoacidosis within the previous six months.	☐	☐	**Please provide documentation**
REAUTHORIZATION			
1. Is the request for reauthorization of therapy?	☐	☐	
2. Has the member had at least 2 visits with a diabetes specialist within the previous 12 months?	☐	☐	**Please provide documentation**
3. Does documentation show that the member is adhering to the treatment plan outlined by a diabetes specialist?	☐	☐	**Please provide documentation**
4. If requesting a new insulin pump, does documentation show that the current pump's warranty expired?	☐	☐	**Please provide documentation**
What medications and/or treatment modalities have been tried in the past for this condition? Please document name of treatment, reason for failure, treatment dates, etc.			
Additional information:			
Physician Signature:			

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy PHARM-120
Origination Date: 08/12/2021
Reviewed/Revised Date: 08/18/2021
Next Review Date: 08/18/2022
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