Tubeless Insulin Pump (Omnipod)
Prior Authorization Form

Fax completed form to:
855-207-0250
For questions regarding this prior authorization, call
866-773-0695

Prior Authorization Vendor for ND Medicaid

ND Medicaid requires that members receiving a prescription for Omnipod meet specific diagnosis and clinical criteria requirements. Criteria for the tubeless insulin pump can be found in the Preferred Diabetic Supplies List (PDSL) available at: www.hidesigns.com/assets/files/ndmedicaid/NDPDL.pdf

Part I: TO BE COMPLETED BY PRESCRIBER REPRESENTATIVE

Member Name	Member Date of Birth	Member Medicaid ID Number	
Prescriber Name	Specialist involved in therapy (if not treating prescriber)		
Prescriber NPI	Telephone Number	Fax Number	
Address	City	State	Zip Code
Requested Product:	**Diagnosis for this request:**		
List all current medications used for control of member's blood glucose:			

Qualifications for Coverage (please answer all of the questions below)	
Is the prescriber trained in the data management platform used with the Omnipod system?	☐ YES ☐ NO
Will the member maintain regular provider visits to review Omnipod data every 3-6 months?	☐ YES ☐ NO
Has the member been adherent to provider appointments for the past 6 months?	☐ YES ☐ NO
Does the member or caregiver have the mental, physical, auditory, visual, and motivational ability to manage the pump?	☐ YES ☐ NO
Will the member receive Omnipod training from Omnipod System Trainer or a healthcare provider?	☐ YES ☐ NO
Has the member received diabetic education within the past year?	☐ YES ☐ NO
Has the member received a tubed insulin pump within the past 4 years?	☐ YES ☐ NO
Is the member experiencing elevated glucose levels from disconnecting due to contact or swimming sports? *If answered "yes", please provide documentation/clinical notes to support this.	☐ YES ☐ NO

Most recent Time in Range % (if available):	**Member's current A1c**:

☐ *I confirm that I have considered a generic or other alternative and that the requested DME is expected to result in the successful medical management of the member.*

Prescriber (or Staff) / Pharmacy Signature**	Date

**: *By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in the member's medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.*

Part II: TO BE COMPLETED BY PHARMACY

PHARMACY NAME:			ND MEDICAID PROVIDER NUMBER:
TELEPHONE NUMBER	FAX NUMBER	DRUG	NDC #