OHIO DEPARTMENT OF MEDICAID

# PRIOR AUTHORIZATION INSULIN PUMPS

| Request Date | Review Type Requested<br>☐ Standard ☐ Urgent |
|---|---|
| Individual's Full Name | Prescriber's Full Name |
| Individual's Date of Birth | Prescriber's NPI Number |
| Individual's Medicaid ID Number | Prescriber's Address |
| **(If Known)** Pharmacy's Name | Prescriber's Phone Number |
| Pharmacy's Phone Number | Prescriber's Fax Number |
| Omnipod or V-GO Device Requested *(Include Model or Strength)* | |

**NEW REQUESTS: Please check all that apply for this individual**

☐ Type 2 DM *(V-Go may only be authorized for Type 2 DM)* ☐ Type 1 DM

☐ The individual has completed a diabetes education program within the preceding 365 days.

☐ The individual regularly works with a certified diabetes educator *(letter or documentation required).*

☐ The individual is on a maintenance insulin regimen involving at least *THREE* injections of insulin per day and frequent self-adjustments of insulin dosage.

☐ The individual has performed glucose self-testing at least 4 times/day on average during the last month.

☐ The individual has been adherent to endocrinologist recommended insulin regimen *(Requires 3 months of monitoring logs and claims history)*

☐ The individual *(or someone assisting the individual)* is capable of managing the pump.

☐ The individual has the following symptoms or conditions (Mark all that apply. *Must meet at least one while compliant with insulin regimen)*

- ☐ Glycated hemoglobin level (HbA1c) greater than 7%.
- ☐ A history of recurring hypoglycemia.
- ☐ Wide fluctuations in blood glucose before mealtime.
- ☐ A marked early morning increase in fasting blood sugar *(dawn phenomenon- glucose level exceeds 200 mg/dl).*
- ☐ A history of severe glycemic excursions.
- ☐ A history of diabetic ketoacidosis

- Initial Limits
  - Omnipod allows 10 pods per 30 days
  - V-GO allows 30 devices per 30 days
- Additional documentation required to support medical necessity for more pods per month

**REAUTHORIZATION REQUESTS: Require prescriber attestation to the following**

- ☐ The individual or someone assisting the individual is capable of managing the pump.
- ☐ There is documented evidence of improvement in diabetes control *(specific to baseline status)*.

☐ I attest that I am a member of the prescriber's staff in accordance with Ohio Administrative Code 5160-9-03, as applicable. Only the prescribing provider or a member of the prescribing provider's staff may request prior authorization.

________________________________________ ______________________________

Prescriber's Signature (or staff of prescriber) Date

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IF a staff member is attesting, please print your name

**Fax To: Ohio Department of Medicaid**
**Fax: (800) 396 - 4111 PA Helpdesk: (877) 518 -1546**
**Hours: Monday – Friday 8:00 am – 8:00 pm EST**