

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Omnipod

Fax back to: (833) 605-4407 Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process,

| Patient Name: | Prescriber Name: |
|------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------|
| Member Number: | Fax: Phone: |
| Date of Birth: | Office Contact: |
| Line of Business: □ Exchange - PA | NPI: State Lic ID: |
| Address: | Address: |
| City, State ZIP: | City, State ZIP: |
| Primary Phone: | Specialty/facility name (if applicable): |
| ☐ REQUEST FOR EXPEDITED REVIEW: By checking the enrollee or the enrollee's ability to regain maxing. | ng this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health o imum function. |
| Drug Name: | |
| Strength: | |
| Directions / SIG: | |
| Please attach any pertinent medi | cal history including labs and information for this member that may support approval. Please answer the following questions and sign. |
| Q1. Is the patient currently es | stablished on therapy with an insulin pump? |
| ☐ Yes | □ No |
| Q2. Does the patient have a 4 times per day? | documented frequency of glucose self-testing an average of at least |
| ☐ Yes | □ No |
| Q3. Is the patient using a cor | ntinuous glucose monitor (CGM)? |
| ☐ Yes | □ No |
| Q4. Is the patient managing tagging adjustments of the insulin do | their diabetes with at least 3 daily insulin injections with frequent self- se for at least 6 months? |
| ☐ Yes | □ No |
| • | documented frequency of glucose self-testing an average of at least wo months OR has the patient been using a continuous glucose wo months? |

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| Patient Name: | Prescriber Name: | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------|--|
| ☐ Yes | □ No | |
| Q6. Has the patient experienced any of the following while on 3 or more daily injections of insulin? a. Elevated glycosylated hemoglobin level (e.g., HbA1c greater than 7 percent); b. History of recurrent hypoglycemia (e.g., blood glucose levels less than 70 mg/dL); c. Wide fluctuations in blood glucose before mealtime; d. "Dawn" phenomenon with fasting blood sugars frequently exceeding 200 mg/dL; e. History of severe glycemic excursion | | |
| ☐ Yes | □ No | |
| Q7. Additional Information: | | |
| | | |
| | | |
| Prescriber Signature | Date | |
| | 2024 Prior Authorization Request | |