

CAREFIRST MD Disposable Insulin Pumps

This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at 888-836-0730. Please contact CVS/Caremark at 855-582-2038 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Disposable Insulin Pumps.

Patient Information

[illegible]

Physician Information

[illegible]

Drug Name (specify drug)

Quantity: _____ **Frequency:** _____ **Strength:** _____

Route of Administration: _____ **Expected Length of Therapy:** _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please check the appropriate answer for each applicable question.

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|-----|---|---|--------------------------|---|--------------------------|
| 1. | Is this request for Omnipod GO? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 2. | Does the patient have a diagnosis of type 2 diabetes mellitus? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 3. | Does the patient require bolus or mealtime insulin? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 4. | Has the patient completed a comprehensive diabetes education program? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 5. | Does the patient have documented frequency of glucose self-testing at least once daily OR has the patient been using a continuous glucose monitor (CGM)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 6. | Does the patient have a hypersensitivity to an ingredient in ALL available basal insulin (e.g., long-acting insulin, intermediate-acting insulin)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 7. | Does the patient require MORE than the plan allowance of 10 pods (2 kits) per month? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 8. | Is the patient currently established on therapy with an insulin pump? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 9. | Does the patient have documented frequency of glucose self-testing an average of at least 4 times per day OR is the patient using a continuous glucose monitor (CGM)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 10. | Has the patient been managing their diabetes with multiple daily insulin injections (i.e., at least 3 injections per day) with frequent self-adjustments of the insulin dose? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 11. | Has the patient completed a comprehensive diabetes education program? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 12. | Does the patient have documented frequency of glucose self-testing an average of at least 4 times per day for the past two months OR has the patient been using a continuous glucose monitor (CGM) for the past two months? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

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|-----|---|---|--------------------------|---|--------------------------|
| 13. | Has the patient experienced an elevated glycosylated hemoglobin level (e.g., HbA1c greater than 7 percent) while on multiple daily injections of insulin (i.e., at least 3 injections per day) for at least 6 months or has the patient experienced ANY of the following while on multiple daily injections of insulin (i.e., at least 3 injections per day) for at least 3 months: A) history of recurrent hypoglycemia (e.g., blood glucose levels less than 70 mg/dL), B) wide fluctuations in blood glucose before mealtime, C) "dawn" phenomenon with fasting blood sugars frequently exceeding 200 mg/dL, D) history of severe glycemic excursions? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 14. | Is this request for an Omnipod product (e.g., Omnipod DASH or Omnipod 5)? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 15. | Does the patient require more than 200 units of insulin within a 72-hour period? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 16. | Does the patient require a starter kit? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 17. | Has the patient received a starter kit within the past five years? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 18. | Does the patient require MORE than the plan allowance of 10 pods per month? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 19. | Does the patient require MORE than the plan allowance of 10 pods per month? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 20. | Does the patient require a starter kit? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 21. | Has the patient received a starter kit within the past five years? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 22. | Does the patient require MORE than the plan allowance of 15 pods per month? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 23. | Does the patient require MORE than the plan allowance of 15 pods per month? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |
| 24. | Does the patient require MORE than the plan allowance of 30 V-GO pumps per month? | Y | <input type="checkbox"/> | N | <input type="checkbox"/> |

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date

Now you can get responses to drug PAs immediately and securely online—without faxes, phone calls, or waiting. How? With electronic prior authorization (ePA)! For more information and to register, go to www.caremark.com/epa.