PA Request Criteria

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CAREFIRST - CF FACETS FEP RSK VF
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 Name: _____ **Date:** 8/25/2025
Patient ID: _____ **Patient Date Of Birth:** _____
Patient Group No: _____ **Patient Phone:** _____ **Physician Name:**
NPI#: **Specialty:**
Physician Office Address: _____ **Physician Office Telephone:**
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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.

1.	Is this request for Omnipod GO?	**Y** ☐	**N** ☐
2.	Does the patient have a diagnosis of type 2 diabetes mellitus?	**Y** ☐	**N** ☐
3.	Does the patient require bolus or mealtime insulin?	**Y** ☐	**N** ☐
4.	Has the patient completed a comprehensive diabetes education program?	**Y** ☐	**N** ☐
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** ☐	**N** ☐
6.	Does the patient have a hypersensitivity to an ingredient in ALL available basal insulin (e.g., long-acting insulin, intermediate-acting insulin)?	**Y** ☐	**N** ☐
7.	Does the patient require MORE than the plan allowance of 10 pods (2 kits) per month?	**Y** ☐	**N** ☐
8.	Is the patient currently established on therapy with an insulin pump?	**Y** ☐	**N** ☐
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** ☐	**N** ☐
10.	Has the patient been managing their diabetes with multiple daily insulin injections?	**Y** ☐	**N** ☐
11.	Has the patient completed a comprehensive diabetes education program?	**Y** ☐	**N** ☐
12.	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** ☐	**N** ☐
13.	Does the patient have a diagnosis of type 1 diabetes mellitus?	**Y** ☐	**N** ☐

14.	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** ☐	**N** ☐
15.	Is this request for an Omnipod product (e.g., Omnipod DASH or Omnipod 5)?	**Y** ☐	**N** ☐
16.	Does the patient require more than 200 units of insulin within a 72-hour period?	**Y** ☐	**N** ☐
17.	Does the patient require a starter kit?	**Y** ☐	**N** ☐
18.	Has the patient received an Omnipod starter kit within the past two years?	**Y** ☐	**N** ☐
19.	Does the patient require MORE than the plan allowance of 10 pods per month?	**Y** ☐	**N** ☐
20.	Does the patient require MORE than the plan allowance of 10 pods per month?	**Y** ☐	**N** ☐
21.	Does the patient require a starter kit?	**Y** ☐	**N** ☐
22.	Has the patient received an Omnipod starter kit within the past two years?	**Y** ☐	**N** ☐
23.	Does the patient require MORE than the plan allowance of 15 pods per month?	**Y** ☐	**N** ☐
24.	Does the patient require MORE than the plan allowance of 15 pods per month?	**Y** ☐	**N** ☐
25.	Is this request for Twiist?	**Y** ☐	**N** ☐
26.	Does the patient require more than 300 units of insulin within a 72-hour period?	**Y** ☐	**N** ☐
27.	Does the patient require a starter kit?	**Y** ☐	**N** ☐
28.	Has the patient received a Twiist starter kit within the past two years?	**Y** ☐	**N** ☐
29.	Does the patient require MORE than 1 Refill Kit (10 cassettes) or 1 Refill Kit with Infusion Sets (10 cassettes plus 10 infusion sets) per month?	**Y** ☐	**N** ☐
30.	Does the patient require MORE than 1 Refill Kit (10 cassettes) or 1 Refill Kit with Infusion Sets (10 cassettes plus 10 infusion sets) per month?	**Y** ☐	**N** ☐
31.	Does the patient require a starter kit?	**Y** ☐	**N** ☐
32.	Has the patient received a Twiist starter kit within the past two years?	**Y** ☐	**N** ☐
33.	Does the patient require MORE than 2 Refill Kits (20 cassettes) or 2 Refill Kits with Infusion Sets (20 cassettes plus 20 infusion sets) per month?	**Y** ☐	**N** ☐
34.	Does the patient require MORE than 2 Refill Kits (20 cassettes) or 2 Refill Kits with Infusion Sets (20 cassettes plus 20 infusion sets) per month?	**Y** ☐	**N** ☐
35.	Does the patient require MORE than the plan allowance of 30 V-GO pumps per month?	**Y** ☐	**N** ☐

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.

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Prescriber (Or Authorized) Signature and Date