BlueCross BlueShield Federal Employee Program

DISPOSABLE INSULIN DELIVERY DEVICES PRIOR APPROVAL REQUEST

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

NOTE: Form must be completed in its **entirety** for processing

Please select one of the following:

❑CeQur Simplicity Patch **❑Omnipod 5** **❑Omnipod DASH** **❑V-go Insulin Delivery System**

1. Does the patient have a diagnosis of type 1 or type 2 diabetes mellitus (DM)? ❑Yes* ❑No
   If YES, please specify which: ❑Type 1 diabetes mellitus (DM) **OR** ❑Type 2 diabetes mellitus (DM)
2. **CeQur Simplicity Patch Request**, please answer the following questions:
   a. Is this a request for a replacement inserter? ❑Yes* ❑No
      If YES, only the manufacturer can provide a replacement inserter. Please contact CeQur Care at 1-888-552-3787 or cequrcare@cequr.com for assistance.
   b. Is the patient using more than 180 units of insulin every 96 hours? ***Please select answer below:***
      ❑Yes: Will the patient need more than 96 patches every 90 days? ❑Yes* ❑No
      If YES, please specify the requested quantity: _____ patches every 90 days
      ❑No: Will the patient need more than 32 patches every 90 days? ❑Yes* ❑No
      If YES, please specify the requested quantity: _____ patches every 90 days
3. **Omnipod 5 or Omnipod DASH Request**: Is the patient using more than 200 units of insulin every 72 hours? ***Select answer below:***
   ❑Yes: Will the patient need more than 90 pods every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ pods every 90 days
   ❑No: Will the patient need more than 30 pods every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ pods every 90 days
4. **V-go Insulin Delivery System Request:** Will the patient need more than 90 devices every 90 days? ❑Yes* ❑No
   If YES, please specify the requested quantity: _____ devices every 90 days
5. Has the patient been using this patch/pod/pump continuously for the last **6 months** excluding samples? ***Please select answer below:***
   ❑NO – this is **INITIATION** of therapy, please answer the following questions:
   a. Has the patient utilized an insulin patch/pod/pump for at least the last 90 days? ❑Yes ❑No*
      If NO, has the patient been insulin dependent requiring more than 3 injections per day with a history of suboptimal blood sugar control for at least the last 90 days? ❑Yes ❑No
   b. Has the patient completed a comprehensive diabetes education program? ❑Yes ❑No
   c. Will the patient use a rapid-acting insulin with the device/patch/pod? ❑Yes ❑No
   d. Does the prescriber agree to monitor the patient's hemoglobin A1c (HbA1c)? ❑Yes ❑No

   ❑YES – this is a PA renewal for **CONTINUATION** of therapy, please answer the following question(s):
   a. Has the patient's hemoglobin A1c (HbA1c) improved or stabilized using an insulin patch/pod/pump? ❑Yes ❑No
   b. **Omnipod 5 Request**: Does the patient have the Omnipod 5 System controller or smartphone app for the requested pods?
      ❑Yes ***(*If YES, please select one of the following below)*** ❑No
      ❑Patient has the Omnipod 5 System controller
      ❑Patient will be using their mobile device in lieu of the Omnipod 5 System controller
   c. **Omnipod DASH Request**: Does the patient have the Omnipod DASH Personal Diabetes Manager (PDM) system for the requested pods? ❑Yes, patient has the Omnipod DASH PDM system ❑No

The information provided on this form will be used to determine the provision of healthcare benefits under a U.S. federal government program, and any falsification of records may subject the provider to prosecution, either civilly or criminally, under the False Claim Acts, the False Statements Act, the mail or wire fraud statutes, or other federal or state laws prohibiting such falsification. **Prescriber Certification:** I certify all information provided on this form to be true and correct to the best of my knowledge and belief. I understand that the insurer may request a medical record if the information provided herein is not sufficient to make a benefit determination or requires clarification and I agree to provide any such information to the insurer.

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***

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