Prescriber Criteria Form

Omnipod Go 2025 PA Fax 6504-A v1 010125.docx
Omnipod Go
Coverage Determination

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS Caremark at **1-855-633-7673.** Please contact CVS Caremark at **1-866-785-5714** with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of Omnipod Go.

Drug Name:
Omnipod Go

Patient Name:		
Patient ID:		
Patient DOB:	**Patient Phone:**	
Prescriber Name:		
Prescriber Address:		
City:	**State:**	**Zip:**
Prescriber Phone:	**Prescriber Fax:**	
Diagnosis:	**ICD Code(s):**	

Please circle the appropriate answer for each question.			
1	Is this a request for continuation of therapy with an insulin pump? [If yes, then no further questions.]	Yes	No
2	Does the patient have diabetes requiring insulin management? [If no, then no further questions.]	Yes	No
3	Does the patient meet one of the following: A) currently self-testing glucose levels, B) will be counseled on self-testing glucose levels, C) using a continuous glucose monitor? [If no, then no further questions.]	Yes	No
4	Has the patient experienced an inadequate treatment response or intolerance to long-acting basal insulin therapy?	Yes	No

Comments: ______________________________

By signing this form, I attest that the information provided is accurate and true as of this date and that the documentation supporting this information is available for review if requested by the health plan.

Prescriber (or Authorized) Signature: ________________________________ Date:____________________