Prescriber Criteria Form

Omnipod 2025 PA Fax 3573-A v3 010125.docx
Omnipod
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.

Drug Name:
Omnipod

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 with multiple daily injections? [If no, then no further questions.]	Yes ◯	No ◯
3	Is the patient self-testing glucose levels 4 or more times per day OR is the patient using a continuous glucose monitor? [If no, then no further questions.]	Yes ◯	No ◯
4	Has the patient experienced any of the following with the current diabetes regimen: A) inadequate glycemic control, B) recurrent hypoglycemia, C) wide fluctuations in blood glucose, D) dawn phenomenon with persistent severe early morning hyperglycemia, E) severe glycemic excursions?	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:_____