

PRIOR AUTHORIZATION REQUEST FORM

Omnipod 5

Omnipod 5 Introkit, Omnipod 5 Pods

For authorization, please answer each question and fax this form PLUS chart notes back to RealRx Medicaid Prior Authorization Department at 385-425-4052.

Failure to submit clinical documentation to support this request will result in a dismissal of the request.

If you have prior authorization questions, please call Pharmacy Customer Service for assistance.

- Healthy U: 855-856-5694
- Healthy U CHIP: 855-203-3633
- Health Choice Utah: 855-864-1404

Disclaimer: Prior authorization request forms are subject to change in accordance with Federal and State notice requirements.

| | | |
|---------------|--------------|-----------------|
| Date: | Member Name: | ID#: |
| DOB: | Gender: | Physician: |
| Office Phone: | Office Fax: | Office Contact: |

Height/Weight:

Preferred Products: Omnipod 5 Introkit, Omnipod 5 Pods

Non-preferred Products: N/A

Note: Other insulin pumps are available under the Durable Medical Equipment (DME) benefit

Product Requested: _____

Directions for Use: _____

| Criteria for Approval (ALL of the following criteria must be met): | Yes | No |
|--|--------------------------|--------------------------|
| 1. Is the disposable insulin pump system being prescribed by an endocrinologist or in consultation with a provider specializing in the treatment of diabetes mellitus? <input type="checkbox"/> For infusion of at least 5 units of insulin per day <input type="checkbox"/> Insulin total daily dose: _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Does the patient and/or caregiver adhere to a comprehensive diabetes treatment plan supervised by the treating provider and can they recognize and respond to the messages, alarms and alerts of the device? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Does the provider attest that the patient is NOT pregnant, on dialysis, or critically ill? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does the provider attest that the patient and/or caregiver has received (or will receive) appropriate ongoing counseling and training for Omnipod use? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Will Omnipod 5 be used in conjunction with a compatible and UT Medicaid-preferred continuous glucose monitor or will be testing blood glucose levels accordingly? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does the provider attest that the patient has NOT been approved for another non-disposable insulin pump other than Omnipod within the last 5 years? If NO , provide following details: Pump details: _____ Date Received: _____ Reason to request Omnipod: _____ | <input type="checkbox"/> | <input type="checkbox"/> |

| Additional criteria for Approval for Type 1 diabetes: (ALL of the following criteria must be met) | | |
|--|--------------------------|--------------------------|
| 7. Is the patient 2 years of age or older? | <input type="checkbox"/> | <input type="checkbox"/> |
| Additional criteria for Approval for Type 2 diabetes: (ALL of the following criteria must be met) | | |
| 8. Is the patient 18 years of age or older? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Does the member meet ONE of the following criteria? <input type="checkbox"/> The patient requires ≥ 3 insulin injections per day and has a hemoglobin A1c% of at least 7%? AND the patient requires ≥ 4 blood glucose tests daily, or is utilizing a continuous glucose monitor (CGM) OR <input type="checkbox"/> The patient has a history of hypoglycemia with dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dl, hypoglycemic unawareness, or nocturnal hypoglycemia OR <input type="checkbox"/> The patient has a loss of manual dexterity | <input type="checkbox"/> | <input type="checkbox"/> |
| Reauthorization | | |
| 1. Has the provider submitted an updated letter with medical justification and updated chart notes demonstrating positive clinical response? | <input type="checkbox"/> | <input type="checkbox"/> |
| PRESCRIBER CERTIFICATION | | |
| I hereby certify this treatment is indicated, necessary and meets the guidelines for use. | | |
| Physician's Signature: | Date: | |

Initial Authorization: Up to six (6) months

Reauthorization: Up to one (1) year

**** Failure to submit clinical documentation to support this request will result in a dismissal of the request.****

Policy: PHARM-HYB-182
 Origination Date: 01/01/2026
 Reviewed/Revised Date:
 Next Review Date:
 Current Effective Date: 01/01/2026

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