TRICARE Prior Authorization Request Form for
Omnipod 5 Kits and Pods

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name: _____ Physician Name: _____
Address: _____ Address: _____
_____ _____
Sponsor ID # _____ Phone #: _____
Date of Birth: Secure Fax #:

Step 2 **Please complete the clinical assessment:**

1. Provider acknowledges that a current PA approval for Omnipod 3 or Omnipod 4 does not grant automatic approval for Omnipod 5. A new PA is required for Omnipod 5.	☐ Acknowledged Proceed to question **2**	
2. Has the patient received this product under the TRICARE PHARMACY benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for the requested product.*	☐ Yes (prior use will be verified) Proceed to question **3**	☐ No Proceed to question **5**
3. Has the patient been successful with therapy as shown by increased time in range (TIR) or improved A1c?	☐ Yes **Sign and date below**	☐ No Proceed to question **4**
4. Has the patient experienced a decrease in hypoglycemic episodes?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
5. Is Omnipod 5 prescribed by or in consultation with an endocrinologist?	☐ Yes proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient have a documented diagnosis of Type 1 diabetes mellitus?	☐ Yes proceed to question **7**	☐ No **STOP** **Coverage not approved**

7. Is the patient on an insulin regimen of 3 or more injections per day using both basal and prandial insulin and has failed to achieve glycemic control after six months of Multiple Daily Injection (MDI) therapy?	☐ Yes proceed to question **9**	☐ No proceed to question **8**
8. Is the patient utilizing another insulin-pump device and is switching to Omnipod 5?	☐ Yes proceed to question **9**	☐ No **STOP** **Coverage not approved**
9. Has the patient completed a comprehensive diabetes education program?	☐ Yes proceed to question **10**	☐ No **STOP** **Coverage not approved**
10. Has the patient demonstrated willingness and ability to play an active role in diabetes self-management?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**

Step 3 **I certify the above is true to the best of my knowledge.** Please sign and date:

_____ _____
Prescriber Signature Date

[15 February 2023]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: