TRICARE Prior Authorization Request Form for
Omnipod and Omnipod DASH

JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTHCARE
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FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

USFHP Pharmacy Prior Authorization Form

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. Has the patient received this medication under the TRICARE benefit in the last 6 months? *Please choose "No" if the patient did not previously have a TRICARE approved PA for Omnipod, Omnipod DASH.*	☐ Yes (subject to verification) Proceed to question **2**	☐ No Proceed to question **3**
2. Has the patient been successful with therapy?	☐ Yes **Sign and date below**	☐ No **STOP** **Coverage not approved**
3. Does the patient have diabetes mellitus?	☐ Yes Proceed to question **4**	☐ No **STOP** **Coverage not approved**
4. Does the patient require insulin therapy?	☐ Yes Proceed to question **5**	☐ No **STOP** **Coverage not approved**
5. Is the patient on an insulin regimen of 3 or more injections per day and has failed to achieve glycemic control after six months of Multiple Daily Injection (MDI) therapy?	☐ Yes Proceed to question **6**	☐ No **STOP** **Coverage not approved**
6. Does the patient perform 4 or more blood glucose tests per day or is using a Continuous Glucose Monitoring (CGM) system?	☐ Yes Proceed to question **7**	☐ No **STOP** **Coverage not approved**

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7. Has the patient completed a comprehensive diabetes education program?	☐ Yes Proceed to question **8**	☐ No **STOP** **Coverage not approved**
8. 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 _____

[18 May 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#:
Date Faxed to MD:	Date Decision Rendered: