Prior Authorization Request Form for

V-Go Disposable Insulin Delivery Device

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

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. Does the patient have a diagnosis of type 2 diabetes mellitus?	☐ Yes Proceed to question 2	☐ No **STOP** Coverage not approved
2. Does the patient require approximately 40 units or less of BASAL insulin daily?	☐ Yes Proceed to question 3	☐ No **STOP** Coverage not approved
3. Does the patient require approximately 36 units or less of BOLUS insulin daily?	☐ Yes Proceed to question 4	☐ No **STOP** Coverage not approved
4. Does the patient require bolus insulin dosing in increments of 2 units per bolus? (that is, does the patient require bolus doses of 2 units, or 4 units, or 6 units, and so on?)	☐ Yes Proceed to question 5	☐ No **STOP** Coverage not approved
5. Has the patient been maintained on stable basal insulin for at least 3 months at dosages ranging from 20 units to 40 units per day?	☐ Yes Proceed to question 6	☐ No **STOP** Coverage not approved
6. Has the patient been using mealtime insulin for at least 3 months?	☐ Yes Sign and date below	☐ No Coverage not approved

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

_____ _____

Prescriber Signature Date

[08 April 2015]

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