| Prescriber Criteria Form<br>Omnipod 2026 PA Fax 3573-A v3 010126.docx<br>Disposable Insulin Pumps<br>Omnipod<br>Coverage Determination |
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| This fax machine is located in a secure location as required by HIPAA regulations.<br>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 Disposable Insulin Pumps. |

| Drug Name (select from list of drugs shown): |
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| **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.** | | | |
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| 1 | Is this a request for continuation of therapy with an insulin pump?<br>[If yes, then no further questions.] | Yes | No |
| 2 | Does the patient have diabetes requiring insulin management with multiple daily injections?<br>[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?<br>[If no, then no further questions.] | Yes | No |
| 4 | Does the patient have type 1 diabetes?<br>[If yes, then no further questions.] | Yes | No |
| 5 | 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? | | |

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| Comments: | _____ |

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| 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:_____** |