



REQUEST FOR PRIOR AUTHORIZATION
OMNIPOD DASH PODS

Prescribing Physician:
Name (First, Last)
Direct Phone #
Fax #
Physician specialty

Patient:
Name (First, Last)
ID #
Phone # Client
Birth Date Sex
M F

Name and title of person completing form (please print)
Product Name: OMNIPOD DASH PODS
Has patient been on the Omnipod Dash?
Please indicate if member has Type 1 Diabetes Type 2 Diabetes
If Type 2 Diabetes, what is the patient's daily insulin requirement?
Has the patient had failure to multiple daily injection insulin administration?
If yes, please provide reasons for failure
Is the patient or caregiver motivated, adherent, knowledgeable and able to monitor blood glucose 3 or more times per day?
Other Information:

Physician's Signature _____ Date ____/____/____

Fax Request and Supporting Documentation (chart notes) to: SGRX @ 313-264-0985

For ScriptGuideRX use only)

Date faxed:
Date received:
Date completed:

Decision (all authorizations are pending valid eligibility)