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? ☐ **Yes** ☐ **No If yes, for how long?**

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? ☐ **Yes** ☐ **No**
If yes, please provide reasons for failure

☐ Abnormal early-morning increase in blood glucose ("dawn phenomenon"), unresponsive to management with long-acting insulin analogue (eg, insulin glargine, insulin detemir) regimens

☐ Child for whom multiple daily insulin injections are impractical or inappropriate

☐ Diabetes complications (eg, neuropathy, nephropathy, retinopathy), and need for more intensive management

☐ Extreme insulin sensitivity

☐ HbA1c greater than 7% (53 mmol/mol), despite intensified multiple daily injection insulin therapy

☐ Hypoglycemia requiring third-party assistance, including unconsciousness, seizure, glucagon administration, and emergency attendance or admission to hospital

☐ Patient is pregnant or planning pregnancy

☐ Wide swings in glycemic control

☐ Other

Is the patient or caregiver motivated, adherent, knowledgeable and able to monitor blood glucose 3 or more times per day? ☐ **Yes** ☐ **No**

Other Information:

Physician's Signature_____**Date**____/___/_____

Office Visit Chart Notes are required for the review

Fax Request to: SGRX @ 313-264-0985

Date faxed: ___/___/___
For ScriptGuideRX use only)
Date received: ___/___/___
Date completed: ___/___/___

Decision (all authorizations are pending valid eligibility)