West Virginia Medicaid
Drug Prior Authorization Form

http://www.dhhr.wv.gov/bms/Pharmacy/Pages/default.aspx

Omnipod Insulin Management System
Prior Authorization Form

Rational Drug Therapy Program
WVU School of Pharmacy
PO Box 9511 HSCN
Morgantown, WV 26506
Fax: 1-800-531-7787
Phone: 1-800-847-3859

Patient Name (Last) | (First) | (M) | WV Medicaid 11 Digit ID# | Date of Birth (MM/DD/YYYY)

Prescriber Name (Last) | (First) | (MI)

Prescriber Address (Street) | (City) | (State) | (Zip)

West Virginia

Prescriber 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Pharmacy Name (if applicable)

Pharmacy Address (Street) | (City) | (State) | (Zip)

West Virginia

Pharmacy 10-Digit NPI# | Phone # (111-222-3333) | Fax # (111-222-3333)

Important Notes: Preauthorization for medical necessity does not guarantee payment.
The use of pharmaceutical samples will not be considered when evaluating the members' medical condition or prior prescription history for drugs that require prior authorization.

Product (Select one)

- ☐ Omnipod Pods
- ☐ Omnipod Dash Pods

Diagnosis | ICD-10 Diagnosis Code

Directions (Include the name of the insulin that will be used in the pods, the number of units of insulin to be used per day, and the frequency of pod changing):

Document all medications currently prescribed for glycemic control for this patient. For each medication, include the medication name, dose, directions for use, start date, and (if no longer taking) the end date along with the reason for discontinuing.

Has the patient received diabetic education? ☐ Yes ☐ No - Not Approved

Is the patient currently self-testing his/her blood glucose? ☐ Yes - **Attach glucose logs from the last 90 days (required)** ☐ No - Not Approved

Indicate if any of the following apply to this patient (Check all that apply):

- ☐ Documented history of recurring hypoglycemia
- ☐ Wide fluctuations in pre-meal glucose
- ☐ History of severe glycemic excursions
- ☐ Experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200mg/dL
- ☐ Current use of an insulin pump (in the last 30 days)

Most Recent Hemoglobin A1C: _____ Date of Most Recent A1C: _____

Other Pertinent Information:

_____

Attestation: Your signature (manually or electronically) certifies that the above request is medically necessary, does not exceed the medical needs of the member, and is documented in your medical records. Medical/Pharmacy records must be made available upon request.

☐ Check here for electronic signature

Prescriber or Pharmacist Signature _____ Date: _____

(MM/DD/YYYY)