INSULIN PUMP
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review

☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis - ICD code plus description:	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently being treated with the requested agent? ☐ Yes ☐ No
   - If yes, has the patient been using the requested product within the past 90 days? ☐ Yes ☐ No
   - If yes, is the patient at risk if therapy is changed? ☐ Yes ☐ No
   - If yes, please specify risk: _____
2. Does the patient currently have an insulin pump (e.g. Omnipod Eros, Minimed, Guardian) but it is not functioning properly AND is past warranty? ☐ Yes ☐ No
3. Does the patient have diabetes mellitus AND requires insulin therapy? ☐ Yes ☐ No
4. Is the patient on an insulin regimen of 3 or more injections per day? ☐ Yes ☐ No
5. Does the patient perform 4 or more blood glucose tests per day or is using Continuous Glucose Monitoring (CGM)? ☐ Yes ☐ No
6. Has the patient completed a comprehensive diabetes education program? ☐ Yes ☐ No
7. Has the patient demonstrated willingness and ability to play an active role in diabetes self-management? ☐ Yes ☐ No
8. Has the patient had ONE of the following while compliant on an optimized multiple daily insulin injection regimen: 1) glycosylated hemoglobin level (HbA1C) greater than 7%, 2) history of recurring hypoglycemia, 3) wide fluctuations in blood glucose before mealtime, 4) dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL, or 5) history of severe glycemic excursions? ☐ Yes ☐ No

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

For all requests continued:

9. Is the patient's age within the manufacturer recommendations for the requested indication for the requested product? ☐ Yes ☐ No

   If no, please give rationale in support of using the requested product for the patient's age: _____

   _____

10. Is there information in support of therapy with a higher dose for the requested indication? ☐ Yes ☐ No

    If yes, please provide supporting information: _____

    _____

Please fax or mail this form to:
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Eagan, MN 55121

TOLL FREE

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