REQUEST FOR PRIOR AUTHORIZATION
OMNIPOD DASH PODS

Prescribing Physician	
Name (First, Last)	
Physician Specialty	
Phone #	Fax #

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

Name and title of person completing form (please print)

1. Product Name: OMNIPOD DASH PODS

2. Has patient been on the Omnipod Dash? ☐ Yes ☐ No

If yes, for how long? _____

4. 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 withlong-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 (please specify):

Is the patient or caregiver motivated, adherent, knowledgeable and able to monitor blood glucose 3 or more times per day?

☐ Yes ☐ No

5. Other Information:

Physician's Signature _____ **Date** _____

Office Visit Chart Notes are required for the review

Fax Request to: SGRX @ 313-264-0985

Date Faxed _____ Date Received _____ Date Completed _____

Decision (all authorizations are pending valid eligibility)

Rev. 032024