Jefferson Health Plans

2024 PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Omnipod

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: □ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.

Please answer the following questions and sign.

Q1. Is the patient currently established on therapy with an insulin pump?

☐ Yes ☐ No

Q2. Does the patient have a documented frequency of glucose self-testing an average of at least 4 times per day?

☐ Yes ☐ No

Q3. Is the patient using a continuous glucose monitor (CGM)?

☐ Yes ☐ No

Q4. Is the patient managing their diabetes with at least 3 daily insulin injections with frequent self-adjustments of the insulin dose for at least 6 months?

☐ Yes ☐ No

Q5. Does the patient have a documented frequency of glucose self-testing an average of at least 4 times per day for the past two months OR has the patient been using a continuous glucose monitor (CGM) for the past two months?

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☐ Yes ☐ No

Q6. Has the patient experienced any of the following while on 3 or more daily injections of insulin? a. Elevated glycosylated hemoglobin level (e.g., HbA1c greater than 7 percent); b. History of recurrent hypoglycemia (e.g., blood glucose levels less than 70 mg/dL); c. Wide fluctuations in blood glucose before mealtime; d. “Dawn” phenomenon with fasting blood sugars frequently exceeding 200 mg/dL; e. History of severe glycemic excursion

☐ Yes ☐ No

Q7. Additional Information:

_____ _____

Prescriber Signature Date

2024 Prior Authorization Request