STATE OF CONNECTICUT DEPARTMENT OF SOCIAL SERVICES
TELEPHONE: 1-866-409-8386 FAX: 1-866-759-4110

CT Medical Assistance Program
Insulin Pump (Omnipod, V-Go) Pharmacy Prior Authorization (PA) Request Form

This form must be completed by the prescribing provider. If the form is missing information, the PA will not be processed.

Prescriber Information	Patient Information
Prescriber's NPI:	Patient Medicaid ID Number:
Prescriber Name:	Patient Name:
Phone #:	Patient DOB:
Fax #:	Primary ICD Diagnosis Code:

Please select only ONE device per prior authorization request form:

- ☐ OmniPod Dash Pods (Gen 4) 5pk & Omni Pod Dash Intro Kit (Gen 4)
- ☐ OmniPod 5 DexG7G6 Pods (Gen 5) & OmniPod 5 DexG7G6 Intro Kit (Gen 5)

- ☐ V-Go 20 Disposable Device (NDC: 08560-9400-03)
- ☐ V-Go 30 Disposable Device (NDC: 08560-9400-02)
- ☐ V-Go 40 Disposable Device (NDC: 08560-9400-01)

Clinical Information

1.	**For patients currently established on insulin pump therapy:** Are the following statements TRUE: 1. Physician monitoring is planned 2. Proper use and continued benefit has been established by diabetes care team	☐ **Yes** ☐ **No**
2.	**For patients NOT currently established on insulin pump therapy:** Are **ALL** relevant below statements TRUE: 1. Patient has a diagnosis of Diabetes Mellitus Type 1 or 2 2. Patient has been testing ≥ 4 times per day for ≥ 8 weeks or is using a continuous glucose monitor (CGM) 3. Patient or caregiver motivated to assume responsibility for self-care and insulin management 4. Patient or caregiver demonstrates knowledge of importance of nutrition including carbohydrate counting and meal planning 5. Patients with Type 2 Diabetes: Has completed a Diabetes Management Program 6. Patients with Type 2 Diabetes: Has self-administered injections ≥ 3 times per day and have performed self-adjusted dose changes for ≥ 6 months (adults) or ≥ 3 months (pediatric) 7. Patient with Type 2 Diabetes: Has experienced 3 ≥ of the following conditions: - Unexplained, nocturnal, or severe hypoglycemia - Hypoglycemia unawareness - Dawn Phenomenon blood glucose > 200 mg/dl - Wide and unpredictable (erratic) swings in blood glucose levels - Glycemic targets within individualized range but lifestyle requires increased flexibility of insulin pump use - Glycosylated hemoglobin (HbA1C) > 7% or outside of individualized targets	☐ **Yes** ☐ **No**

If you answered 'NO' to the applicable question above as it relates to your patient, a Letter of Medical Necessity (LMN) must be reviewed for consideration. Please provide all relevant information relating to the medical necessity (see Conn. Gen. Stat § 17b-259b(a)) for this patient. Submit request, via email, to rx.lmn@ct.gov.

Please Note: Pharmacies should not be contacting prescribers to provide pre-signed PA forms or submitting pre-signed forms for PA, nor should prescribing providers be requesting that pharmacies perform PA activities for them. PA requests must originate from the prescriber, and only the prescriber should sign the form at the time of PA submission.

I certify that documentation is maintained in my files and the information given is true and accurate for the medication requested, subject to penalty under section 17b-99 of the Connecticut General Statutes and sections 17-83k-1-13 and 4a-7, inclusive, of the Regulations of Connecticut State Agencies. I certify that the client is under my clinic's/practice's ongoing care. I certify that I am a practitioner and hold a current, unrestricted license that allows me to prescribe medication and that I am enrolled in the CT Medical Assistance Program.

Prescriber Signature:_____ **Date:**_____