

Patient Name (Last)	(First)	(M)	WV Medicaid 11 Digit ID#	Date of Birth (MM/DD/YYYY)
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber Name (Last)	(First)	(MI)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Prescriber Address (Street)	(City)	(State)	(Zip)
<input type="text"/>	<input type="text"/>	West Virginia	<input type="text"/>

Prescriber 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Pharmacy Name (if applicable)
<input type="text"/>

Pharmacy Address (Street)	(City)	(State)	(Zip)
<input type="text"/>	<input type="text"/>	West Virginia	<input type="text"/>

Pharmacy 10-Digit NPI#	Phone # (111-222-3333)	Fax # (111-222-3333)
<input type="text"/>	<input type="text"/>	<input type="text"/>

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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)	Diagnosis	ICD-10 Diagnosis Code
<input type="checkbox"/> Omnipod Pods <input type="checkbox"/> Omnipod Dash Pods	<input type="text"/>	<input type="text"/>

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 glyceemic 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)