Field Name	Field Description
Prior Authorization Group Description	**Insulin Pumps**
Drugs	Omnipod Dash Intro Kit, Omnipod Dash Pods, Omnipod 5 G6 Intro Kit, Omipod 5 G6 Pods, OmniPod GO, MiniMed 630G Insulin Pump, MiniMed 670G Insulin Pump, T:Slim X2 Basal_IQ Insulin pump, T:Slim X2 Control-IQ, V-Go 24 hour disposable system and any newly approved insulin pump
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	None
Required Medical Information	See "Other Criteria"
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist, a certified diabetes care and education specialist (CDCES), or an obstetrician/gynecologist
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months.
Other Criteria	**Initial Authorization** • Diagnosis – diabetes • One of the following o Type 1 diabetes or other insulin-deficient forms of diabetes (e.g. cystic-fibrosis related diabetes) o Treatment with multiple daily doses (≥ 3) of insulin o Pregnancy o Continuation of therapy for patient new to plan o For OmniPod GO: trial and failure of a long-acting insulin or a medical reason why long-acting insulin cannot be used (adherence, etc.) **Reauthorization** • One of the following: o Type 1 diabetes or other insulin-deficient form of diabetes o Prescriber attests member has benefited from, and has continued need for, therapy with an insulin pump o Initial approval was based on continuation of therapy for patient new to plan. o For OmniPod GO: continuous use of approved insulin compatible with device • Continuation of therapy based on a diagnosis of pregnancy alone is not eligible for reauthorization **Medical Director/clinical reviewer must override criteria when, in his/her**

Revision/Review Date 2/2024	**professional judgement, the requested item is medically necessary.**