**Omnipod, V-Go (insulin pump)**

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| Criteria 1 | Omnipod, V-Go (insulin pump) |

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| **Criteria Title** | Diabetic Insulin Pump | | |
| **Criteria Subtitle** | Omnipod, V-Go | | |
| **Approval Level** | GCNSeqNo | | |
| **Products**     |  |  | | --- | --- | | Preferred |  | | Non-Preferred |  | | Brand |  | | Generic |  | | Other |  | | Drug Name | Corresponding Code (s) | Type of Code (GCNSeqNo, HICL, NDC) |
| OMNIPOD | 082933 | GCNSeqNo |
| OMNIPOD | 083217 | GCNSeqNo |
| OMNIPOD | 083219 | GCNSeqNo |
| OMNIPOD | 082513 | GCNSeqNo |
| OMNIPOD | 082512 | GCNSeqNo |
| OMNIPOD | 083229 | GCNSeqNo |
| V-GO | 068529 | GCNSeqNo |
| V-GO | 068533 | GCNSeqNo |
| V-GO | 068534 | GCNSeqNo |

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| **Sequence Number** | **Question ID** | **Default Next Question ID** | **Question Type** | **Question Text** | **Choice Text** | **Next Question ID** |
| 1 | 1001 |  | Select | Is the patient new to therapy (initial authorization request) or continuing therapy (re-authorization request)? | New Start (initial authorization request) | 1002 |
| Continuation (re-authorization request) | 1234 |
| 2 | 1002 |  | Select | Is this request being prescribed in accordance with Food and Drug Administration (FDA) approved labeling? | Y | 1003 |
| N | 1235 |
| 3 | 1003 |  | Select | Does the patient require insulin injections greater than or equal to 3 times a day and self-home glucose monitoring greater than or equal to 4 times a day? | Y | 1004 |
| N | 1235 |
| 4 | 1004 |  | Select and Free Text | Is the patient adherent to the insulin therapy recommended by an endocrinologist as demonstrated by monitoring logs and claims history maintained for at least 3 months? | Y | 1005 |
| N | 1235 |
| 5 | 1005 |  | Select | Does the patient meet ONE of the following criteria while compliant with insulin regimen:   1. HgA1C greater than 7 percent 2. History of recurrent hypoglycemia 3. Wide fluctuations in blood glucose before mealtime 4. A marked early morning increase in fasting blood sugar (dawn phenomenon glucose level exceeds 200mg/dL) 5. History of ketoacidosis 6. A history of severe glycemic excursions | Y | 1006 |
| N | 1235 |
| 6 | 1006 |  | Select | Is the patient capable of managing the pump and that the desired improvement in metabolic control can be achieved (or someone assisting the individual)? | Y | 1007 |
| N | 1235 |
| 7 | 1007 |  | Select | Has the patient completed a comprehensive diabetes education program within the previous 365 days? | Y | 1008 |
| N | 1235 |
| 8 | 1008 |  | Select and Free Text | Has the provider submitted a letter or documentation indicating the patient regularly works with a certified diabetes educator? | Y | 1009 |
| N | 1235 |
| 9 | 1009 |  | Select | Which product is being requested? | Omnipod | 1010 |
| V-Go | 1011 |
| 10 | 1010 |  | Select | Does the patient have a diagnosis of Type 1 or Type 2 diabetes? | Y | END (Pending Manual Review) |
| N | 1235 |
| 11 | 1011 |  | Select | Does the patient have a diagnosis of Type 2 diabetes? | Y | END (Pending Manual Review) |
| N | 1235 |
| 12 | 1234 |  | Select and Free Text | Has the provider submitted documentation of objective evidence of improvement in control of diabetes relative to baseline? | Y | END (Pending Manual Review) |
| N | 1235 |
| 13 | 1235 |  | Free Text | Please provide the rationale for the medication being requested. | END (Pending Manual Review) | |

LENGTH OF AUTHORIZATIONS: 365 days

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| **Last Approved** | 4/13/2023 |
| **Other** |  |