SENTARA HEALTH PLANS

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

This is a group specific benefit

Subcutaneous Insulin Pumps and Insulin Pump Supplies

Drug Requested: (select one product below)

PHARMACY BENEFIT INSULIN PUMP SYSTEMS	
❑ **iLet Bionic Pancreas**	❑ **CeQur Simplicity™**
❑ **twiist™ AID System**	
Provider please note: All other insulin pumps (e.g., Minimed 780G, t:slim X2, Mobi) can be accessed under the medical benefit	

PROVIDER PLEASE NOTE: Only one prior authorization form is required to be submitted for the request of any formulary insulin pump. If approved, an authorization will be entered for corresponding insulin pump supplies (e.g., infusion set, reservoir, tubing).

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member Sentara #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight (if applicable): _____ **Date weight obtained:** _____

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- Will the member be discontinuing a previously prescribed insulin pump device and/or supplies if approved for the requested insulin pump?

  ❑ Yes **OR** ❑ No

- If yes, please list the insulin pump device and/or supplies that will be discontinued and the insulin pump and/or supplies that will be initiated upon approval along with the corresponding effective date.

  Medication to be discontinued: _____ **Effective date:** _____

  Medication to be initiated: _____ **Effective date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

❑ **Subcutaneous Insulin Pumps and Supplies**

Group Specific Benefit: VCUHS Members Only

ALL the following criteria must be met:

- ❑ Requested insulin pump meets FDA-approved age requirements
- ❑ Insulin injections are required multiple times daily or an insulin pump will be used for maintenance of blood sugar control
- ❑ Multiple blood glucose tests are required daily or a continuous glucose monitor is being used
- ❑ Member must meet at least **ONE** of the following:
  - ❑ Diagnosis of Type 1 diabetes mellitus
  - ❑ Diagnosis of Type 2 diabetes mellitus
  - ❑ Gestational Diabetes
- ❑ Member has a confirmed diagnosis of diabetes and has experienced inadequate blood glucose control while using multiple daily insulin injections, as demonstrated by at least **ONE** of the following **(select all that apply)**:
  - ❑ Abnormal early-morning increase in blood glucose ("dawn phenomenon"), unresponsive to management with long-acting insulin analogue (e.g., insulin glargine, insulin detemir) regimens
  - ❑ Child for whom multiple daily insulin injections are impractical or inappropriate
  - ❑ Diabetes complications (e.g., neuropathy, nephropathy, retinopathy), and need for more intensive management
  - ❑ Extreme insulin sensitivity
  - ❑ History of recurring hypoglycemia (less than 70 mg/dL)
  - ❑ Hypoglycemia with recurrent episodes, including unconsciousness, seizure, glucagon administration, and emergency attendance and/or admission to hospital and recurrent prolonged hospitalizations
  - ❑ Individual is pregnant or planning pregnancy

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- ❑ Provider attests individual or caregiver is adherent, capable of using the devices safely (either by themselves or a caregiver), knowledgeable, and able to monitor blood glucose 3 or more times per day
- ❑ Provider attests office staff and clinical team has the experience and expertise to manage and support individuals using an insulin infusion pump
- ❑ Provider attests member will be evaluated by the treating physician at least once every 6 months

❑ Replacement Device

- ❑ Member has been previously approved for an insulin pump
- ❑ At least **ONE** of the following problems have occurred which limits the use of the member's current insulin pump
  - ❑ Abuse of equipment
  - ❑ Misuse of equipment
  - ❑ Reagent or instrument failure/defective devices
  - ❑ Defects in product design
  - ❑ Product instability
  - ❑ Failure to perform according to performance characterized in package insert
  - ❑ Incorrect test results (falsely elevated or decreased glucose results) that cause or contributed to an incorrect patient diagnosis and/or treatment
  - ❑ Unexplained quality control (QC) failures
  - ❑ Any other device problems that may compromise patient health or safety
- ❑ Provider or member must submit documentation that the member's current insulin pump device is not under warranty, including the date of warranty expiration

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pharmacy paid claims or submitted chart notes.****

Approved by Pharmacy and Therapeutics Committee:
REVISED/UPDATED/REFORMATTED: 4/29/2026