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Magellan Rx MANAGEMENT

# NYRx the Medicaid Pharmacy Program

## Preferred Insulin Pump or Patch Prior Authorization Worksheet

**Fax Number: 1-800-268-2990**

Processing may be delayed if information submitted is illegible or incomplete. If your fax includes the standardized fax form, only the **Member Name, DOB, ID,** and **Clinical Criteria** need to be completed and faxed as an attachment to process your request.

### ENROLLEE INFORMATION

Enrollee Last Name: _____

Enrollee First Name: _____

Date of Birth: _____

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): _____

Enrollee Street Address: _____

City: _____ State: _____ Zip: _____

### PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

Prescriber NPI Number: _____

Board-Certified Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip: _____

Prescriber Phone: _____ Prescriber Fax: _____

### REQUESTED PUMP OR PATCH – DRUG INFORMATION

Drug Name: _____

Drug Strength: _____

Quantity: _____ Refills: _____

Directions: _____

Is the patient established on this product?

☐ Yes ☐ No

If **Yes**, date therapy was initiated: _____


 Revision Date: 10/04/2023

Enrollee's Full Name: _____

**CLINICAL CRITERIA**

1. What is the patient's diagnosis?
   - ☐ Gestational Diabetes (Stop here if patient has gestational diabetes.)
   - ☐ Diabetes Mellitus Type 1
   - ☐ Diabetes Mellitus Type 2
   - ☐ Other: _____
2. Is the requested product Omnipod GO™?
   - ☐ Yes (continue to question 4)
   - ☐ No (continue to question 3)
3. Does the patient require multiple (i.e., 3 or more) injections of insulin per day with frequent self-adjustments of insulin dose for at least 6 months prior to initiation of the insulin pump, and has failed to achieve acceptable control of blood sugars that are not explained by poor motivation or compliance?
   ☐ Yes ☐ No
   If **No**, provide rationale:
4. Has the patient completed a comprehensive diabetes education program?
   ☐ Yes ☐ No
5. Does the patient have one of the following?
   a. HbA1c > 7%: ☐ Yes ☐ No
   b. History of recurring hypoglycemia: ☐ Yes ☐ No
   c. Wide fluctuations in blood glucose before mealtime ( > 140 mg/dL): ☐ Yes ☐ No
   d. Dawn phenomenon in fasting state ( > 200 mg/dL): ☐ Yes ☐ No
   e. History of severe glycemic excursions: ☐ Yes ☐ No

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of said plan, the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

**Fax Number:** 1-800-268-2990
**Prior Authorization Call Line:** 1-877-309-9493
**Billing Questions:** 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.

For the Preferred Diabetic Supply list, please visit:
https://newyork.fhsc.com/downloads/providers/NYRx_PDSP_preferred_supply_list.pdf