Nevada Medicaid – Molina Healthcare

Insulin Pump Prior Authorization Request Form

Please provide the information below, please print your answer, attach supporting documentation, sign, date, and return to our office as soon as possible to expedite this request**. Please FAX responses to: (844) 259-1689. Phone: (833) 685-2103.**

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Molina ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Device Information (required)

Device Name:	Additional Information:
❑ Check if request is for **continuation of therapy**	

Clinical Information (required)

Mark all that apply:

☐ The recipient has a diagnosis of Diabetes Mellitus Type I or Gestational Diabetes. ICD-10_____

☐ The product is prescribed by or in consultation with an endocrinologist.

☐ The product requested is approved for the age of the recipient per the manufacturer's label.

The recipient has been compliant on their current antidiabetic regimen for at least the last six months (requiring at least three injections per day).

☐ The recipient has a documented history of recurring hypoglycemia.

☐ The recipient has wide fluctuations in pre-meal blood glucose, history of severe glycemic excursion or experiencing "Dawn" phenomenon with fasting blood glucose exceeding 200mg/dL.

☐ The recipient has prior use of an insulin pump with documented frequency of glucose self-testing of at least four times per day in the month immediately prior to the request.

Recertification (for renewal of a previously approved prior authorization):

☐ The recipient has a documented positive clinical response to the product (including current HbA1c).

Requests for Non-preferred products:

If the recipient cannot be switched to any of the available preferred products, select the reason(s) or special circumstance(s) that a preferred product cannot be used:

☐ Recipient had an allergic reaction to the product or related supply.

☐ Visual impairment requires the use of requested product.

☐ Medically necessary justification (e.g., mental or physical limitation) why the recipient needs to remain on their current product: _____

_____

☐ Recipient has been trained on the requested non-preferred product.

☐ Recipient has benefited from the use of the requested non-preferred product.

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information and/or documentation the physician feels is important that should be considered for this review (if providing attachment please indicate "see attachment"):

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call (833) 685-2103.
This form may be used for non-urgent requests and faxed to (844) 259-1689.
