BOSTON MEDICAL CENTER HEALTHNet PLAN

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WELL SENSE HEALTH PLAN

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Pharmacy Policy

Continuous Subcutaneous Insulin Infusion – Unified Formulary

Policy Number: 9.339
Version Number: 1.1
Version Effective Date: 9/1/2021

Product Applicability	☐ **All Plan+ Products**
Well Sense Health Plan	**Boston Medical Center HealthNet Plan**
☐ New Hampshire Medicaid	☒ MassHealth ACO
	☒ MassHealth MCO
	☐ Qualified Health Plans/ConnectorCare/Employer Choice Direct
	☐ Senior Care Options

Note: Disclaimer and audit information is located at the end of this document.

Policy

Reference Table

Products that require PA*	No PA
Omnipod®	
Omnipod Dash®	
V-Go®	

***Other forms of CSII may be available through DME. Prior authorizations received for a continuous subcutaneous insulin infusion should be faxed back.**

The following NDCs are included within the rebate agreement and will usually reject at the pharmacy as prior authorization required. Any NDC that is not listed here is not included in the rebate agreement and therefore will usually reject at the pharmacy level.

Omnipod® and Omnipod Dash®
08508-3000-01 Omnipod 5 Intro kit (GSN)
08508-1120-05 Omnipod 5 Pack Pod (GSN 061024)

08508-3000-21 Omnipod 5 Refill 5 Pack (GSN)
08508-2000-11 Omnipod Dash Intro Kit (GSN)
08508-2000-05 Omnipod Dash 5 Pack Pods (GSN 061024)
08508-2000-00 Omnipod Dash PDM Kit (GSN: 070933)
08508-1140-02 Omnipod Starter Kit (GSN 063929)

V-Go®
08560-9400-03 V-Go 20-unit disposable device (GSN 068529)
08560-9400-02 V-Go 30-unit disposable device (GSN 068533)
08560-9400-01 V-Go 40-unit disposable device (GSN 068534)

Procedure:

Approval Diagnosis:	• Diabetes Mellitus
Approval Criteria: *Omnipod®* *Omnipod Dash®* *V-Go®*	Prescriber provides documentation of ALL of the following:* 1. Diagnosis of diabetes mellitus 2. If the request is for V-Go®, member is ≥18 years of age 3. Member's current treatment plan involves testing blood glucose at least 4 times per day† 4. Member is currently receiving multiple daily insulin injections (at least three) or an insulin pump‡ 5. Member's A1c > 7.0% or does not meet documented target treatment § 6. **ONE** of the following: a. Frequent hypoglycemia b. Fluctuations of more than 100 mg/dL in blood glucose before mealtime c. Dawn phenomenon with fasting blood sugars frequently exceeding 200 mg/dL. d. History of severe glycemic excursions *Notes:* ** If the request is for a pediatric member and does not meet criteria for approval, please forward to the clinical reviewer of the day for case by case review.* *† Members who are nonadherent to the recommended testing may still be approvable if the prescriber states that testing is recommended or prescribed as at least four times daily.* *‡Members not receiving multiple daily insulin injections due to physical disability, visual impairment, cognitive impairment, or age <18 years may bypass this requirement. Other comorbidities should be evaluated on a case by case basis.* *§Members meeting all other criteria may be considered on a case-by-case basis*
Denial Criteria:	Cases that do not meet the approval criteria will be denied. If a request is denied and the prescriber has additional clinical documentation, a **new** prior authorization request must be submitted.
Duration of Authorization:	Prior authorization may be issued for **3 months.**
Recertification Criteria:	Recertification requests may be approved for up to **1** year with documentation of improvement in diabetic control/relative stability (e.g.,

	provider attestation or A1c improvement or improvement in hypoglycemia or hyperglycemia can be considered to meet this requirement).

Appendix:

Stability

Stability on continuous subcutaneous insulin infusion may generally be accepted for approval if the member has an appropriate diagnosis. Stability may be determined based on consistent monthly claims for the requested device, provider attestation, or documentation in medical records. However, stability is not sufficient to bypass approval criteria for members noted to be stabilized on continuous subcutaneous insulin infusion using samples.

Grandfathering

Information is not applicable

Responsibility and Accountability

Policy History

Original Approval Date	Original Effective Date	Policy Owner	Approved by
5/13/2021	7/1/2021	Pharmacy Services	Pharmacy & Therapeutics (P&T) Committee

Policy Revisions History			
Review Date	**Summary of Revisions**	**Revision Effective Date**	**Approved by**
5/13/2021	Created policy for MH Unified Formulary, policy date 3/15/21	7/1/2021	P&T Committee
6/4/2021	State updates to NDCs for Omnipod based on products available	9/1/2021	P&T Committee

Next Review Date

5/2022

Other Applicable Policies

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References

Reference to Applicable Laws and Regulations, if Any

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