PROVIDER*ALERT*

AmeriHealth Caritas Louisiana

To: **AmeriHealth Caritas Louisiana Providers**

Date: **November 11, 2021**

Subject: **New Policy for Insulin Pumps**

Summary: A new medical policy regarding insulin pumps has been approved by the Louisiana Department of Health.

AmeriHealth Caritas Louisiana would like to make you aware of the attached policy that has been approved by the Louisiana Department of Health in accordance with La. R.S. 46:460.54 and **will become effective December 13, 2021.**

Questions: Thank you for your continued support and commitment to the care of our members. If you have questions about this communication, please contact AmeriHealth Caritas Louisiana Provider Services at 1-888-922-0007 or your Provider Network Management Account Executive.

Missed an alert?
You can find a complete listing of provider alerts on the Provider Newsletters and Updates page of our website.

Where can I find more information on COVID-19?
AmeriHealth Caritas Louisiana has updated its website to streamline communications and important notifications about COVID-19. Please visit http://amerihealthcaritasla.com/covid-19 for up-to-date information for both providers and members, including frequently asked questions, and important provider alerts from AmeriHealth Caritas Louisiana and the Louisiana Department of Health.

Field Name	Field Description
Prior Authorization Group Description	Insulin Pumps
Drugs	Omnipod Dash, insulin delivery pods only (Notes: The Omnipod Dash PDM (Personal Diabetes Manager) is provided direct by Insulet and should not be requested by the prescriber/billed to the plan.) This policy does not apply to pumps reviewed and/or covered by the Medical Benefit including, but not limited to V-Go 24-hour disposable system and continuous pumps such as MiniMed and t:slim X2. Requests for these products are referred to the plan's Utilization Management team for review.
Covered Uses	Medically accepted indications are defined using the following sources: the Food and Drug Administration (FDA), Micromedex, American Hospital Formulary Service (AHFS), United States Pharmacopeia Drug Information for the Healthcare Professional (USP DI), the Drug Package Insert (PPI), or disease state specific standard of care guidelines.
Exclusion Criteria	None
Required Medical Information	See "Other Criteria"
Age Restrictions	None
Prescriber Restrictions	Prescribed by or in consultation with an endocrinologist
Coverage Duration	If all of the criteria are met, the request will be approved for 12 months. If the criteria are not met, the request is referred to a Medical Director/Clinical Reviewer for medical necessity review.
Other Criteria	Initial Authorization • Diagnosis – diabetes • One of the following o ≤ 18 years with type 1 diabetes or other insulin-deficient forms of diabetes (i.e. cystic-fibrosis related diabetes) o Continuation of therapy for patient new to plan o Treatment with multiple daily doses (≥ 3) of insulin and one of the following ▪ Persistently inadequate glycemic control (i.e. HbA1C ≥ 7% on multiple consecutive readings with one being within the last 3 months, frequent bouts of

Revision/Review Date 6/2021	**hypoglycemia, overt microvascular complications)** ▪ **History of acutely dangerous symptoms (i.e. severe glycemic excursions; brittle diabetes; nocturnal hypoglycemia; hypoglycemia unawareness, ketosis)** ▪ **Other difficult to manage symptoms/scenarios (i.e. "dawn" phenomenon; extreme insulin sensitivity; very low insulin requirements)** ▪ **Pregnancy** **Reauthorization** • **One of the following:** o **Child or adolescent with type 1 diabetes or other insulin-deficient form of diabetes** o **Documentation of positive clinical response (i.e. improved HbA1C; reduced frequency of severe hypoglycemia episodes; target time in range [TIR] > 70% or time below range < 4%) with 1st reauthorization** o **Initial approval was based on continuation of therapy for patient new to plan.** • **Continuation of therapy based on a diagnosis of pregnancy alone is not eligible for reauthorization** **Medical Director/clinical reviewer must override criteria when, in his/her professional judgement, the requested item is medically necessary.**