Prior Authorization Review Panel

CHC-MCO Policy Submission

A separate copy of this form must accompany each policy submitted for review.
Policies submitted without this form will not be considered for review.

Plan: PA Health & Wellness	**Submission Date: 11/2023**
Policy Number: PHW.PDL.754	**Effective Date: 01/08/2024** **Revision Date: 11/2023**
Policy Name: Tubeless Insulin Delivery Devices	

Type of Submission – Check all that apply:

- ✓ **New Policy**
- ☐ **Revised Policy***
- ☐ **Annual Review - No Revisions**
- ✓ **Statewide PDL** - *Select this box when submitting policies for Statewide PDL implementation and when submitting policies for drug classes included on the Statewide PDL.*

***All revisions to the policy must be highlighted using track changes throughout the document.**

Please provide any changes or clarifying information for the policy below:

Name of Authorized Individual (Please type or print): **Venkateswara R. Davuluri, MD**	**Signature of Authorized Individual:**

Clinical Policy: Tubeless Insulin Delivery Devices

Reference Number: PHW.PDL.754
Effective Date: 01/08/2024
Last Review Date: 11/2023

Revision Log

Policy/Criteria
Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.

It is the policy of PA Health & Wellness® that Tubeless Insulin Delivery Devices are **medically necessary** when the following criteria are met:

I. Requirements for Prior Authorization of Continuous Glucose Monitoring Products

A. Prescriptions That Require Prior Authorization

1. A non-preferred Tubeless Insulin Delivery Device.

2. A Tubeless Insulin Delivery Device with a prescribed quantity that exceeds the quantity limit.

B. Review of Documentation for Medical Necessity

In evaluating a request for prior authorization of a prescription for Tubeless Insulin Delivery Device, the determination of whether the requested prescription is medically necessary will take into account whether the member:

1. For a non-preferred Tubeless Insulin Delivery Device, cannot use the preferred Tubeless Insulin Delivery Devices because of medical reasons as documented by the prescriber **AND**

2. If a prescription for a Tubeless Insulin Delivery Device is for a quantity that exceeds the quantity limit, the determination of whether the prescription is medically necessary will also take into account the guidelines set forth in PA.CP.PMN.59 Quantity Limit Overrides.

NOTE: If the member does not meet the clinical review guidelines above but, in the professional judgement of the physician reviewer, the services are medically necessary to meet the medical needs of the member, the request for prior authorization will be approved.

C. Clinical Review Process

Prior authorization personnel will review the request for prior authorization and apply the clinical guidelines in Section B. above to assess the medical necessity of a prescription for a

Tubeless Insulin Delivery Device. If the guidelines in Section B. are met, the reviewer will prior authorize the prescription. If the guidelines are not met, the prior authorization request will be referred to a physician reviewer for a medical necessity determination. Such a request for prior authorization will be approved when, in the professional judgment of the physician reviewer, the services are medically necessary to meet the medical needs of the member

D. Approval Duration:
6 months

Reviews, Revisions, and Approvals	Date
Policy created	11/2023