

UnitedHealthcare Pharmacy  
Clinical Pharmacy Programs

Program Number	2026 P 2278-6
Program	Prior Authorization/Medical Necessity
Medication	Omnipod® 5, Twiist™
P&T Approval Date	5/2022, 9/2022, 11/2023, 11/2024, 3/2025, 3/2026
Effective Date	6/1/2026

**1. Background:**

External insulin pumps are used for managing individuals with diabetes and deliver insulin by continuous subcutaneous infusion. OmniPod 5 is indicated for management of type 1 diabetes in persons aged 2 and older and in persons with type 2 diabetes aged 18 and older. Twiist is indicated in persons aged 6 and older with type 1 diabetes. Members will be required to meet the following coverage criteria.

**2. Coverage Criteria<sup>a</sup>:**

**A. Initial Authorization**

1. **Omnipod 5** or **Twiist** will be approved based on **one** of the following criteria:

a. **All** of the following:

(1) **One** of the following:

- (a) For Omnipod 5: Diagnosis of diabetes
- (b) For Twiist: Diagnosis of Type 1 diabetes

**-AND-**

(2) **All** of the following<sup>b</sup>:

- (a) Patient regularly tests blood glucose  $\geq 4$  times/day or utilizes a continuous glucose monitor (CGM) for  $\geq 8$  weeks
- (b) Patient has completed a diabetes management program
- (c) Patient injects insulin  $\geq 3$  times/day

**-AND-**

(3) **Both** of the following:

- (a) Patient or caregiver is motivated to assume responsibility for self-care and insulin management
- (b) Patient or caregiver demonstrates knowledge of importance of nutrition including carbohydrate counting and meal planning.

**-OR-**

b. For continuation of therapy

**Authorization will be issued for 12 months.**

**B. Reauthorization**

1. **Omnipod 5** or **Twist** will be approved for continuation of therapy based on the following criteria<sup>b</sup>:

a. Documentation of positive clinical response

**Authorization will be issued for 12 months.**

<sup>a</sup> State mandates may apply. Any federal regulatory requirements and the member specific benefit plan coverage may also impact coverage criteria. Other policies and utilization management programs may apply.

<sup>b</sup> In Florida, Maine, Tennessee, and Texas only, diabetes medications may be approved based on both of the following: 1) Provider attests use of this product is medically necessary; and- 2) If applicable, clinical characteristics exist that preclude the use of the covered preferred alternative(s) and use of the covered preferred alternative(s) could result in worsening of patient’s condition or inadequate treatment (document alternatives and clinical information related to worsening/inadequate treatment).

**3. Additional Clinical Rules:**

- Notwithstanding Coverage Criteria, UnitedHealthcare may approve initial and re-authorization based solely on previous claim/medication history, diagnosis codes (ICD-10) and/or claim logic. Use of automated approval and re-approval processes varies by program and/or therapeutic class.
- Supply limits may be in place.

**4. References:**

1. American Diabetes Association Professional Practice Committee for Diabetes. (2026). 7. Diabetes Technology: Standards of Care in Diabetes—2026. *Diabetes Care*, 49(Suppl. 1), S150–S165.
2. Blonde L, Umpierrez G, Reddy S, et al.; American Association of Clinical Endocrinology Clinical Practice Guideline: Developing a Diabetes Mellitus Comprehensive Care Plan- 2022 Update. *Endocrine Practice* 28(2022)923-1049.

Program	Prior Authorization/Medical Necessity – Omnipod 5
<b>Change Control</b>	
5/2022	New program.
9/2022	Added continuation of therapy. Clarified that CGM could be used to monitor blood glucoses.
11/2023	Annual review. Updated references.
11/2024	Annual review. Updated references.

3/2025	Added Twiist to criteria. Removed requirement for hypoglycemia, unpredictable blood glucose swings, or HbA1C outside of goal.
3/2026	Annual review. Updated references.