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Visit [go.covermymeds.com/OptumRx](http://go.covermymeds.com/OptumRx) to begin using this free service.  
Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

# Glucovance® (glyburide-metformin) Prior Authorization Request Form (Page 1 of 2)

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Member Information <small>(required)</small>	Provider Information <small>(required)</small>
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Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

## Medication Information (required)

Medication Name:		Strength:	Dosage Form:
<input type="checkbox"/> Check if requesting <b>brand</b>		Directions for Use:	
<input type="checkbox"/> Check if request is for <b>continuation of therapy</b>			

## Clinical Information (required)

**Select the diagnosis below:**

Type 2 diabetes mellitus

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**The approval criteria is based on the guidance provided by the Centers for Medicare & Medicaid Services (CMS), the Pharmacy Quality Alliance, the American Geriatric Society and the National Committee for Quality Assurance (NCQA). "Use of High Risk Medications in the Elderly" is measure 238 of the Centers for Medicare & Medicaid Services Physician Quality Reporting System.**

**Risk acknowledgment:**

Does the provider acknowledge that this drug has been identified by the Centers for Medicare and Medicaid Services as a high risk medication in the 65 and older population?  Yes  No

Does the provider wish to proceed with the originally prescribed medication?  Yes  No

**Coverage of the drug is approvable after demonstrated failure to the alternatives below or we receive information as to why they would be inappropriate.**

**Select the medications the patient has a failure, contraindication, or intolerance to:**

<input type="checkbox"/> Alogliptin-metformin	<input type="checkbox"/> Jentaduo
<input type="checkbox"/> Glimepiride	<input type="checkbox"/> Jentaduo XR
<input type="checkbox"/> Glipizide	<input type="checkbox"/> Kazano
<input type="checkbox"/> Glipizide-metformin	<input type="checkbox"/> Kombiglyze XR
<input type="checkbox"/> Invokamet	<input type="checkbox"/> Segluromet
<input type="checkbox"/> Invokamet XR	<input type="checkbox"/> Synjardy
<input type="checkbox"/> Janumet	<input type="checkbox"/> Synjardy XR
<input type="checkbox"/> Janumet XR	<input type="checkbox"/> Xigduo XR

Does the patient have a failure, contraindication, or intolerance to a sulfonylurea (Amaryl, glimepiride, glipizide, glipizide extended-release (ER), Glucotrol, or Glucotrol XL) used *in combination* with a metformin product [Glucophage, Glucophage XR, metformin, metformin ER (generic Fortamet), metformin ER (generic Glucophage XR), metformin ER (generic Glumetza), or Riomet]?  Yes  No

**If YES, please indicate ALL specific combinations:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

This document and others if attached contain information that is privileged, confidential and/or may contain protected health information (PHI). The Provider named above is required to safeguard PHI by applicable law. The information in this document is for the sole use of OptumRx. Proper consent to disclose PHI between these parties has been obtained. If you received this document by mistake, please know that sharing, copying, distributing or using information in this document is against the law. **If you are not the intended recipient, please notify the sender immediately.**

Office use only: Glucovance-GlyburideMetformin\_CMS\_2019Jan-W



# Glucovance<sup>®</sup> (glyburide-metformin) Prior Authorization Request Form (Page 2 of 2)

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**Quantity limit requests:**

What is the quantity requested per DAY? \_\_\_\_\_

**What is the reason for exceeding the plan limitations?**

- Titration or loading-dose purposes
- Patient is on a dose-alternating schedule (e.g., one tablet in the morning and two tablets at night, one to two tablets at bedtime)
- Requested strength/dose is not commercially available
- There is a medically necessary justification why the patient cannot use a higher commercially available strength to achieve the same dosage and remain within the same dosing frequency. **Please specify:** \_\_\_\_\_
- Other: \_\_\_\_\_

**Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?**

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Please note:

This request may be denied unless all required information is received.  
If the patient is not able to meet the above standard prior authorization requirements, please call 1-800-711-4555.  
For urgent or expedited requests please call 1-800-711-4555.  
This form may be used for non-urgent requests and faxed to 1-800-527-0531.