OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit 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

Metformin extended-release products (Fortamet®, Glucophage XR®, Glumetza®) Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
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:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:
❑ Type 2 diabetes mellitus
❑ Other diagnosis: ____ ICD-10 Code(s): _________________________________

Medication history:
Does the patient have a history of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR)? ❑ **Yes** ❑ **No**
Does the patient have a documented history of an inadequate response to metformin extended-release (generic Glucophage XR) as evidenced by Hemoglobin A1c level that is above the patient's goal? ❑ **Yes** ❑ **No**
Does the patient have a documented history of intolerance to metformin extended-release (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction)? ❑ **Yes** ❑ **No**
Does the patient have a history of greater than or equal to 12 week trial of metformin immediate-release? ❑ **Yes** ❑ **No**
Does the patient have a documented history of an inadequate response to metformin immediate-release as evidenced by Hemoglobin A1c level that is above the patient's goal? ❑ **Yes** ❑ **No**
Does the patient have a documented history of intolerance to metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction)? ❑ **Yes** ❑ **No**

Select the medications the patient has a failure, contraindication, or intolerance to:
❑ Metformin extended-release (ER) (generic Fortamet)
❑ Metformin ER (generic Glucophage XR)
❑ Metformin ER (generic Glumetza)
❑ Riomet
❑ Riomet ER

Reauthorization:
Has the patient experienced an objective response to therapy demonstrated by an improvement in Hemoglobin A1c from baseline? ❑ **Yes** ❑ **No**

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: ____

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Metformin extended-release products (Fortamet®, Glucophage XR®, Glumetza®) Prior Authorization Request Form (Page 2 of 2)

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

____

____

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 1-844-403-1028.

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