PRIOR AUTHORIZATION CRITERIA

BRAND NAME
(generic)

FORTAMET
(metformin extended-release)

GLUMETZA
(metformin extended-release)

Status: Client Requested Criteria
Type: Initial Prior Authorization ***Ref # C15557-A***

CRITERIA FOR APPROVAL

1	Does the patient have a diagnosis of diabetes with a history of a trial with a duration of 12 weeks or longer, where the medical record (e.g., chart notes, laboratory values) will provide documentation of an inadequate response to metformin ER (generic Glucophage XR) as evidenced by a Hemoglobin A1c level above the patient's goal? [If yes, then skip to question 4.] [Note: Chart documentation is required to be submitted.]	Yes	No
2	Will the medical record (e.g., chart notes, laboratory values) provide documentation of an intolerance to metformin ER (generic Glucophage XR) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction)? [If yes, then skip to question 4.] [Note: Chart documentation is required to be submitted.]	Yes	No
3	Will the medical record (e.g., chart notes, laboratory values) provide documentation of an allergic reaction to any inactive ingredients contained in metformin ER (generic Glucophage XR) be submitted with this form? [Note: Chart documentation is required to be submitted.]	Yes	No
4	Does the patient have a diagnosis of diabetes with a history of a trial where the medical record (e.g., chart notes, laboratory values) will provide documentation of an inadequate response to metformin immediate-release (IR) of 12 weeks or longer as evidenced by a Hemoglobin A1c level above the patient's goal? [Note: Chart documentation is required to be submitted.]	Yes	No
5	Will the medical record (e.g., chart notes, laboratory values) provide documentation of an intolerance to metformin IR which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction)? [Note: Chart documentation is required to be submitted.]	Yes	No

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Mapping Instructions		
	Yes	**No**
1.	Go to 4	Go to 2
2.	Go to 4	Go to 3
3.	Go to 4	Deny
4.	Approve, 36 months	Go to 5
5.	Approve, 36 months	Deny

REFERENCES
N/A

Written by: UM Development (ME)
Date Written: 02/2019
Revised:
Reviewed: Medical Affairs: (TKP) 03/2019

The Participating Group signed below hereby accepts and adopts as its own the criteria for use with Prior Authorization, as administered by CVS Caremark.

_____ _____
Signature Date

_____
Client Name

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