

Fortamet[®], Glucophage XR[®], Glumetza[®] Prior Authorization Request Form (Page 1 of 2)

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:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below:					
<input type="checkbox"/> Type 2 diabetes mellitus					
<input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information:					
Does the patient have a history of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there 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? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have a history of greater than or equal to 12 week trial of metformin extended-release (generic Fortamet)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there documented history of an inadequate response to metformin extended-release (generic Fortamet) as evidenced by Hemoglobin A1c level that is above the patient's goal? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there documented history of intolerance to metformin extended-release (generic Fortamet) which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g., dose reduction)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Does the patient have a history of greater than or equal to 12 week trial of metformin immediate-release? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there documented history of an inadequate response to metformin immediate-release as evidenced by Hemoglobin A1c level that is above the patient's goal? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Is there 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)? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Will article(s) published in the peer-reviewed medical literature showing that the requested drug is likely to be more efficacious to this patient than metformin extended-release (generic Glucophage XR) be submitted to ProAct [®] with this form? <input type="checkbox"/> Yes <input type="checkbox"/> No					
<i>**Please note: Documentation of the above question is required to be submitted along with this fax</i>					



1230 US Highway 11
Gouverneur, NY 13642
Phone: 1-877-635-9545

Prior Authorization Fax: 1-844-712-8129

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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.

Please fax this form to 1-844-712-8129 to initiate a prior authorization review for the member and medication above.

Please note: plan benefits may limit or exclude coverage of specific medications including those requested on this form.

I certify, to the best of my knowledge, the statements and information provided on this form are factual and correct.

Provider/Representative (and Title): _____ Date: _____

PROACT INTERNAL USE ONLY:

Clinical Review Decision

Approved, through

Denied (documentation attached, if necessary)

Tracking:

1st Attempt

2nd Attempt

Letter Mailed:

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 ProAct. 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: Fortamet-GlucophageXR-Glumetza_Jan_2018