



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

## Fortamet® (metformin extended-release [ER]), Glumetza® (metformin ER) Prior Authorization Request Form

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

| Member Information <small>(required)</small> |        |      | Provider Information <small>(required)</small> |        |            |
|--|--------|------|--|--------|------------|
| 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 <small>(required)</small>                                |  |                     |              |
|---|--|---------------------|--------------|
| 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 <small>(required)</small>  |
|---|
| <p><b>Continuation of therapy:</b><br/>           Is this a continuation of prior therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>           If "yes" to the above question, please submit documentation (e.g., medical records, chart notes, pharmacy claims) or provide the dates, duration, and previous regimen used below: <b>(REQUIRED)</b></p> <hr/> <hr/> |

|   |
|---|
| <p><b>Select the diagnosis below:</b><br/> <input type="checkbox"/> Type 2 diabetes mellitus<br/> <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____</p> |
|---|

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|---|
| <p><b>Clinical information:</b><br/>           Has the patient had a failure of metformin ER (generic for Glucophage XR)? <input type="checkbox"/> Yes <input type="checkbox"/> No<br/>           Are there contraindications or absolute drug interactions with existing therapy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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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?

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Please note: This request may be denied unless all required information is received. 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.

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 Office use only: Fortamet-Glumetza-metforminER\_GoldCoast\_2017Sep-W