

Fortamet, Glucophage XR, Glumetza - Arizona Prior Authorization Request Form

Please complete this **entire** form and fax it to: **866-940-7328**. If you have questions, please call **800-310-6826**.

**This form may contain multiple pages. Please complete all pages to avoid a delay in our decision.
Allow at least 24 hours for review.**

Section A – Member Information

First Name:	Last Name:	Member ID:
Address:		
City:	State:	ZIP Code:
Phone:	DOB:	Allergies:
Primary Insurance Information (if any):		
Is the requested medication: <input type="checkbox"/> New or <input type="checkbox"/> Continuation of Therapy? If continuation, list start date: _____		
Is this patient currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No If recently discharged, list discharge date: _____		

Section B - Provider Information

First Name:	Last Name:	M.D./D.O.
Address:	City:	State: ZIP code:
Phone:	Fax:	NPI #: Specialty:
Office Contact Name / Fax attention to:		

Section C - Medical Information

Medication:	Strength:
Directions for use:	Quantity:
Diagnosis (Please be specific & provide as much information as possible):	ICD-10 CODE:
Is this member pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is this member's due date? _____	

Section D – Previous Medication Trials

Medication Name	Strength	Directions	Dates of Therapy	Reason for failure / discontinuation

Section E – Additional information and Explanation of why preferred medications would not meet the patient's needs: Please refer to the patient's PDL at www.uhcprovider.com for a list of preferred alternatives

Member First name:	Member Last name:	Member DOB:
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Clinical and Drug Specific Information

ALL REQUESTS

The following information MUST be included upon submission:

- Medication name, dose, and duration
 Relevant medical records and laboratory results

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of greater than or equal to 12 week trial of metformin extended-release (generic Glucophage XR) with submission of medical records (e.g., chart notes, laboratory values) documenting any of the following? <i>(If yes, check which applies and complete section D above)</i></p> <input type="checkbox"/> An inadequate response to metformin extended-release (generic Glucophage XR) as evidenced by the following: <ul style="list-style-type: none"> <input type="checkbox"/> For patients with diabetes diagnosis, the hemoglobin A1C level is above patient's goal <input type="checkbox"/> 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)
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of greater than or equal to 12 week trial of metformin immediate-release with submission of medical records (e.g., chart notes, laboratory values) documenting any of the following? <i>(If yes, check which applies and complete section D above)</i></p> <input type="checkbox"/> An inadequate response to metformin immediate-release as evidenced by the following: <ul style="list-style-type: none"> <input type="checkbox"/> For patients with diabetes diagnosis, the hemoglobin A1C level is above patient's goal <input type="checkbox"/> Intolerance to metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)
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BRAND FORTAMET / BRAND GLUMETZA

<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Does the patient have a history of greater than or equal to 12 week trial of metformin extended-release (generic Fortamet) with submission of medical records (e.g., chart notes, laboratory values) documenting <u>one</u> of the following? <i>(If yes, check which applies and complete section D above. DOCUMENTATION REQUIRED)</i></p> <input type="checkbox"/> An inadequate response to metformin extended-release (generic Fortamet) as evidenced by the following: <ul style="list-style-type: none"> <input type="checkbox"/> For patients with diabetes diagnosis, the hemoglobin A1C level is above patient's goal <input type="checkbox"/> Intolerance to metformin extended-release (generic Fortamet) which is unable to be resolved with
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<input type="checkbox"/> Yes <input type="checkbox"/> No	<p>Has the physician submitted 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)?</p> <p><i>If yes, submit supporting medical literature and list rationale:</i></p>
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Provider Signature: _____ **Date:** _____

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