UnitedHealthcare Community Plan

Fortamet, Glucophage XR, Glumetza
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: □ New or □ Continuation of Therapy? If continuation, list start date: _____

Is this patient currently hospitalized? □ Yes □ 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? □ Yes □ 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

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Member First name:	Member Last name:	Member DOB:

Clinical and Drug Specific Information

ALL REQUESTS

The following information below <u>MUST</u> be included upon submission:

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

□ **Yes** □ **No**	**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?** *(If yes, check which applies and complete section D above)* □ An inadequate response to metformin extended-release (generic Glucophage XR) as evidenced by the following: □ For patients with diabetes diagnosis, the hemoglobin A1C level is above patient's goal □ 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 with submission of medical records (e.g., chart notes, laboratory values) documenting any of the following?** *(If yes, check which applies and complete section D above)* □ An inadequate response to metformin immediate-release as evidenced by the following: □ For patients with diabetes diagnosis, the hemoglobin A1C level is above patient's goal □ Intolerance to metformin immediate-release which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction)

BRAND FORTAMET / BRAND GLUMETZA

□ **Yes** □ **No**	**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?** *(If yes, check which applies and complete section D above)* □ An inadequate response to metformin extended-release (generic Fortamet) as evidenced by the following: □ For patients with diabetes diagnosis, the hemoglobin A1C level is above patient's goal □ 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)
□ **Yes** □ **No**	**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 AND generic Fortamet)?** *If yes, submit supporting medical literature and list rationale:*

Provider Signature: _____ Date: _____