BlueCross BlueShield
Federal Employee Program

METFORMIN

Glumetza* (extended-release metformin, modified release), Riomet (metformin oral solution), Riomet ER* (extended-release metformin oral suspension), Metformin extended-release (modified release), Metformin extended-release (osmotic)

*Prior authorization for the brand formulation applies only to formulary exceptions due to being a non-covered medication.

Pre - PA Allowance

None

Prior-Approval Requirements

Age **Glumetza and Metformin ER osmotic only:** 18 years of age or older
Riomet and Riomet ER only: 10 years of age or older

Diagnosis

Patient must have the following:

Diabetes mellitus Type 2

AND ONE of the following for **Glumetza and Metformin ER osmotic only**:

1. Inadequate response
   a. Submission of medical records (e.g. chart notes, laboratory values) documenting a history of a minimum of 3 month trial with **each** of the following:
      i. Immediate release metformin
      ii. Extended-release metformin (generic Glucophage XR)
   b. Patient must have a HbA1c greater than 7.0%

2. Intolerance
   a. Submission of medical records (e.g. chart notes, laboratory values) documenting an intolerance which is unable to be resolved with attempts to minimize the adverse effects where appropriate (e.g. dose reduction) with a history of minimum of a 1 month trial with **each** of the following:
      i. Immediate release metformin
      ii. Extended-release metformin (generic Glucophage XR)
   b. Patient must have a documented HbA1c

Riomet and Riomet ER only:

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1. Documentation that the patient is unable to swallow or has difficulty swallowing metformin tablets
2. Patient must have a HbA1c greater than 7.0%, unless patient has been established on metformin therapy for at least 3 months

AND documentation of the following for **ALL** formulations:

1. Estimated glomerular filtration rate (eGFR) ≥ 30 mL/minute/1.73 m^2
2. **NO** metabolic acidosis, including diabetic ketoacidosis

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Prior - Approval Limits

Quantity

Medication (BRAND with approved Formulary Exception only)	Quantity
Glumetza 500 mg	360 tablets per 90 days **OR**
Glumetza 1000 mg	180 tablets per 90 days

***Maximum daily limit of any Glumetza combination: 2000mg**

Medication	Quantity
Metformin ER osmotic 500 mg	360 tablets per 90 days **OR**
Metformin ER osmotic 1000 mg	180 tablets per 90 days

***Maximum daily limit of any Metformin ER osmotic combination: 2500mg**

Medication	Quantity
Riomet 500 mg/5 mL	2365 mL per 90 days
Riomet ER 500 mg/5 mL (**with approved Formulary Exception only**)	1892 mL per 90 days

Duration 12 months

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*Prior authorization for the brand formulation applies only to formulary exceptions due to being a non-covered medication.

Prior – Approval *Renewal* Requirements

Age **Glumetza and Metformin ER osmotic only:** 18 years of age or older
Riomet and Riomet ER only: 10 years of age or older

Diagnosis

Patient must have the following:

Diabetes mellitus Type 2

AND documentation of **ALL** of the following**:**

1. Submission of medical records (e.g., chart notes, laboratory values) documenting a HbA1c level ≤ 7.0% **OR** HbA1c has decreased by at least 1.0% from baseline
2. Estimated glomerular filtration rate (eGFR) ≥ 30 mL/minute/1.73 m^2
3. **NO** metabolic acidosis, including diabetic ketoacidosis

All approved requests are subject to review by a clinical specialist for final validation and coverage determination once all required documentation has been received. Current utilization, including samples, does not guarantee approval of coverage.

Prior - Approval *Renewal* Limits

Same as above