BlueCross BlueShield Federal Employee Program

GLUMETZA
PRIOR APPROVAL REQUEST

Send completed form to:
Service Benefit Plan
Prior Approval
P.O. Box 52080 MC 139
Phoenix, AZ 85072-2080
Attn. Clinical Services
Fax: 1-877-378-4727

Additional information is required to process your claim for prescription drugs. Please complete the patient portion, and have the prescribing physician complete the physician portion and submit this completed form.

Patient Information (required)			**Provider Information (required)**		
Date:			Provider Name:		
Patient Name:			Specialty:	NPI:	
Date of Birth:	Sex: ❑Male ❑Female		Office Phone:	Office Fax:	
Street Address:			Office Street Address:		
City:	State:	Zip:	City:	State:	Zip:
Patient ID: **R**			Physician Signature:		

PHYSICIAN COMPLETES

****PA is not required for brand or generic Glucophage XR and IR****

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

Glumetza

(extended-release metformin, modified release)

NOTE: Form must be completed in its **entirety** for processing

Please select strength(s) and provide quantity:

❑ **500mg quantity _____ per 90 days** ❑ **1000mg quantity _____ per 90 days**

****Check www.fepblue.org/formulary to confirm which medication is part of the patient's benefit**

*****Non-covered branded medications must go through prior authorization and the formulary exception process**

Is this request for brand or generic? ❑Brand ❑Generic

1. Does the patient have a diagnosis of type 2 diabetes mellitus (DM)? ❑Yes ❑No
2. Does the patient have an estimated glomerular filtration rate (eGFR) of greater than or equal to 30mL/minute/1.73m^2? ❑Yes ❑No
3. Does the patient have metabolic acidosis, including diabetic ketoacidosis? ❑Yes ❑No
4. What is the patient's hemoglobin A1c (HbA1c)? _____ %
5. Has the patient been on Glumetza continuously for the last **6 months**, excluding samples? ***Please select answer below:***

❑ **NO** – this is **INITIATION** of therapy, please answer the following questions:

a. Has the patient had a minimum of three months of therapy with immediate-release (IR) metformin? ❑Yes***** ❑No

****If YES***, has the patient had a minimum of three months of therapy with extended-release (ER) metformin, the equivalent to Glucophage XR? ❑Yes ❑No

b. Has the patient had an intolerance to both immediate-release metformin and extended-release metformin, the equivalent to Glucophage XR, after a minimum of a one month trial? ❑Yes***** ❑No

****If YES***, were attempts made to minimize the adverse effects where appropriate? ❑Yes ❑No

❑ **YES** – this is a PA renewal for **CONTINUATION** of therapy, please answer the questions below:

a. Has the patient's hemoglobin A1c (HbA1c) decreased by at least 1.0 percent from baseline? ❑Yes ❑No

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To ensure a quick and accurate response to your prior approval request, please **submit medical records (e.g., chart notes, laboratory values)** pertaining to the diagnosis only. Please do not send in medical records of other diagnoses in order to streamline the process. Please use this page as a **guideline** of what documentation is required to process the prior authorization request.

***For more efficient processing, please provide the page number of the documented information in the medical record**

Documentation Required:

❒Estimated glomerular filtration rate (eGFR) **PAGE _____ of _____**
❒**NO** metabolic acidosis, including diabetic ketoacidosis **PAGE _____ of _____**
❒HbA1c level **PAGE _____ of _____**

Documentation Required for <u>INITIATION</u> of Therapy:

❒**ONE** of the following:

- **Inadequate Response**: A history of a minimum of 3 month trial with **each** of the following: **PAGE _____ of _____**
  - Immediate release metformin
  - Extended-release metformin (generic Glucophage XR)

- **Intolerance**: Unable to be resolved with attempts to minimize the adverse effects where appropriate with a history of minimum of a 1 month trial with **each** of the following: **PAGE _____ of _____**
  - Immediate release metformin
  - Extended-release metformin (generic Glucophage XR)

Documentation Required for <u>CONTINUATION</u> of Therapy:

❒HbA1c has decreased by at least 1.0% from baseline **PAGE _____ of _____**