BlueCross BlueShield Federal Employee Program

RIOMET
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.

Riomet

(metformin oral solution)

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

Please select dosage form: ❑**IR 500 mg/5 mL** ❑**ER 500 mg/5 mL**

****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

IR Request: Will the patient need more than 2365 milliliters every 90 days? ❑Yes***** ❑No

If YES, please specify the requested quantity: _____ mL per 90 days

ER Request: Will the patient need more than 1892 milliliters every 90 days? ❑Yes***** ❑No

If YES, please specify the requested quantity: _____ mL per 90 days

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 Riomet continuously for the last **6 months**, excluding samples? ***Please select answer below:***

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

   a. Is there documentation that the patient is unable to swallow or has difficulty swallowing metformin tablets? ❑Yes ❑No

   b. Has the patient been established on metformin therapy for at least three months? ❑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 INITIATION of Therapy:

❒Unable to swallow or has difficulty swallowing metformin tablets **PAGE _____ of _____**

Documentation Required for CONTINUATION of Therapy:

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

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Message:

Attached is a Prior Authorization request form.

For your convenience, there are 3 ways to complete a Prior Authorization request:

Electronically Online (ePA) Results in 2-3 **minutes** **FASTEST AND EASIEST**	Now you can get responses to drug Prior Authorization requests **securely** online. **Online** submissions may receive **instant** responses and do not require faxing or phone calls. Requests can be made 24 hours a day, 7 days a week. For more information on electronic prior authorization (ePA) and to register, go to **Caremark.com/ePA.**
Phone (4-5 **minutes** for response)	The FEP Clinical Call Center can be reached at **(877)-727-3784** between the hours of 7AM-9PM Eastern Time. A live representative will assist with the Prior Authorization, asking for the same information contained on the attached form. Please review the form and have your answers ready for faster service. The process over the phone takes on average between 4 and 5 minutes.
Fax (3-5 **days** for response)	Fax the attached form to **(877)-378-4727**. Requests sent via fax will be processed and responded to within 5 business days. The form must be filled out completely, if there is any missing information the Prior Authorization request cannot be processed. ***Please only fax the completed form once as duplicate submissions may delay processing times.***