Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Antihyperglycemic-Biguanides, Fortamet, Glumetza (Metformin HCL ER (MOD) and Metformin HCL ER (OSM))
Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Antihyperglycemic-Biguanides, Fortamet, Glumetza (Metformin HCL ER (MOD) and Metformin HCL ER (OSM)).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

3. Does the member have a diagnosis of type 2 diabetes mellitus, **AND**
   □ No □ Yes

4. Has documented failure/intolerance to Metformin IR and generic Metformin 500 mg ER after adequate trial (3 months) **AND** after documentation of all three of the following strategies to mitigate GI intolerance:
   a. Slow dose titration of Metformin IR or generic 500 mg ER tabs (dose increase every two weeks) to maximally tolerated dose (up to 2000 mg daily), **AND**
   b. Member has been instructed to take with food (as seen on SIG), **AND**
   c. Member has been switched from Metformin IR to generic Metformin 500 mg ER tabs; with adequate trial of 3 months

   □ No □ Yes

For continuation of therapy, please respond to additional questions below.

1. Adherence (>80%) to diabetic regimen, **AND**
   □ No □ Yes

2. Must continue to meet inclusion criteria, **AND**
   □ No □ Yes

3. Documented A1C lowering of 1% from initial or A1C now at goal
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. If no to any of the above questions, please provide any additional supporting information that should be taken into consideration:

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**

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