CareFirst Family of health care plans

CVS caremark™

Prior Authorization Form

Fortamet, Glumetza

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Fortamet, Glumetza.

Drug Name (select from list of drugs shown)

Fortamet (metformin extended-release)	Glumetza (metformin extended-release)	Metformin Extended-Release Tablets

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone:

Prescribing Physician

Physician Name:

_____ Physician

Phone: _____

Physician Fax:

_____ Physician

Address: _____

City, State, Zip: _____ _____

Diagnosis: _____ **ICD Code:**

Comments: _____

Please circle the appropriate answer for each question.

1. Is the requested drug being prescribed for an FDA-Approved indication OR an indication supported in the compendia of current literature (examples: AHFS, Micromedex, current accepted guidelines)?	Y N
2. Has the patient experienced an intolerance to generic Glucophage XR?	Y N

Fortamet-Glumetza 9/17

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date