

Prior Authorization Form
<p>Fortamet, Glumetza</p> <p>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.</p>

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 _____ Physician	Name: _____
Phone: _____ Physician	Fax: _____
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

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

Prescriber (Or Authorized) Signature and Date