

Prior Authorization Form

CAREFIRST

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
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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. Has the patient experienced an intolerance to generic Glucophage XR? [If yes, then prescriber MUST submit chart notes or other documentation supporting date of trial and reason for intolerance to generic Glucophage XR.]  Y  N

[If no, then no further questions.]

2. Have chart notes or other documentation supporting date of trial and reason for intolerance to generic Glucophage XR been submitted to CVS Health?  Y  N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

<b>Prescriber (Or Authorized) Signature and Date</b>