

OPTIMA HEALTH PLAN

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request. All other information may be filled in by office staff; fax to 1-800-750-9692. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. Incomplete form will delay authorization process.

Drug Requested: **Glumetza®** (metformin hydrochloride ER)

DRUG INFORMATION: Complete information below. Authorization process will be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ Length of Therapy: _____

Diagnosis: _____ ICD Code, if applicable: _____

- **Recommended maximum dose: 2000mg/day.**

CLINICAL CRITERIA: Check below ALL that apply. Boxes must be checked to qualify or authorization process will be delayed.

- Patient has tried and failed at least 30 days of therapy with:
 - metformin ER (generic Glucophage® XR)

AND

- metformin osmER (generic Fortamet®)

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

*Approved by Pharmacy and Therapeutics Committee: 4/17/2014

REVISED/UPDATED: 4/22/2014; 10/8/2014; 10/31/2014; 5/21/2015; 11/19/2015; 12/27/2015; 3/29/2016; 12/16/2016; 8/13/2017.