METFORMIN
PRIOR AUTHORIZATION REQUEST
PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is REQUIRED. Incomplete forms will be returned for additional information. For formulary information please visit *www.myprime.com*. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

☐ Standard review
☐ Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION **Date of Service (if differs from Today's Date):** _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis:
☐ Type 2 diabetes mellitus
☐ Other (ICD code, plus description): _____

Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:

For all requests:

1. Is the patient currently treated with the requested agent? ☐ Yes ☐ No
   If yes, is the patient currently stable on the requested agent? ☐ Yes ☐ No
2. Does the patient have any FDA labeled contraindications to the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindications: _____
   _____
3. Has the patient tried and had an inadequate response to at least one non-targeted generic metformin product? ☐ Yes ☐ No
   If yes, please specify: _____
   _____
4. Was at least one non-targeted generic metformin product discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
   If yes, please specify: _____
   _____
5. Does the patient have an intolerance or hypersensitivity to a non-targeted generic metformin product that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please explain intolerance/hypersensitivity: _____
   _____

Please continue to the next page.

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):

6. Does the patient have an FDA labeled contraindication to ALL non-targeted generic metformin products that is not expected to occur with the requested agent? ☐ Yes ☐ No
   If yes, please specify FDA labeled contraindication: _____
   _____
7. Is at least one non-targeted generic metformin product not in the best interest of the patient based on medical necessity? ☐ Yes ☐ No
8. Is at least one non-targeted generic metformin product expected to be ineffective based on the known clinical characteristics of the patient and the known characteristics of the prescription drug; OR cause a significant barrier to the patient's adherence of care; OR worsen a comorbid condition; OR decrease the patient's ability to achieve or maintain reasonable functional ability in performing daily activities; OR cause an adverse reaction or cause physical or mental harm? ☐ Yes ☐ No
9. Has the patient tried another prescription drug in the same pharmacologic class or with the same mechanism of action at least one non-targeted generic metformin product and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event? ☐ Yes ☐ No
   If yes, please specify: _____
   _____
10. Is the requested agent medically necessary and appropriate for the patient? ☐ Yes ☐ No
11. Does the requested quantity (dose) exceed the maximum FDA labeled dose for the requested indication? ☐ Yes ☐ No
    If yes, please give information to support therapy with a higher dose for the requested indication: _____
    _____
    If no, is there information to support why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit? ☐ Yes ☐ No
    If yes, please provide supporting information: _____
    _____

Please fax or mail this form to:
Prime Therapeutics LLC
Clinical Review Department
2900 Ames Crossing Road Suite 200
Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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