

Metformin Prior Authorization with Quantity Limit Program Summary

POLICY REVIEW CYCLE

Effective Date
04-01-2025

Date of Origin

POLICY AGENT SUMMARY PRIOR AUTHORIZATION

Target Brand Agent(s)	Target Generic Agent(s)	Strength	Targeted MSC	Available MSC	Final Age Limit	Preferred Status
Riomet	metformin hcl oral soln	500 MG/5ML	M ; N ; O ; Y	O ; Y		
Metformin hydrochloride	Metformin HCl Tab	625 MG	M ; N ; O ; Y	M		
Metformin hydrochloride	metformin hcl tab	750 MG	M ; N ; O ; Y	N		
Glumetza	Metformin HCl Tab ER 24HR Modified Release 1000 MG	1000 MG	M ; N ; O ; Y	O ; Y		
Glumetza	Metformin HCl Tab ER 24HR Modified Release 500 MG	500 MG	M ; N ; O ; Y	O ; Y		
	Metformin HCl Tab ER 24HR Osmotic 1000 MG	1000 MG	M ; N ; O ; Y	Y		
	Metformin HCl Tab ER 24HR Osmotic 500 MG	500 MG	M ; N ; O ; Y	Y		

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
	Metformin HCl Tab ER 24HR Osmotic 1000 MG	1000 MG	60	Tablets	30	DAYS			
	Metformin HCl Tab ER 24HR Osmotic 500 MG	500 MG	150	Tablets	30	DAYS			
Glumetza	Metformin HCl Tab ER 24HR Modified Release 1000 MG	1000 MG	60	Tablets	30	DAYS			
Glumetza	Metformin HCl Tab ER 24HR Modified Release 500 MG	500 MG	120	Tablets	30	DAYS			
Metformin hydrochloride	Metformin HCl Tab	625 MG	120	Tablets	30	DAYS			
Metformin hydrochloride	metformin hcl tab	750 MG	90	Tablets	30	DAYS			
Riomet	Metformin HCl Oral Soln 500 MG/5ML	500 MG/5ML	780	mLs	30	DAYS			

CLIENT SUMMARY – PRIOR AUTHORIZATION

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
	Metformin HCl Tab ER 24HR Osmotic 1000 MG	1000 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
	Metformin HCl Tab ER 24HR Osmotic 500 MG	500 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
Glumetza	Metformin HCl Tab ER 24HR Modified Release 1000 MG	1000 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
Glumetza	Metformin HCl Tab ER 24HR Modified Release 500 MG	500 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
Metformin hydrochloride	metformin hcl tab	750 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ;

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
Metformin hydrochloride	Metformin HCl Tab	625 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
Riomet	metformin hcl oral soln	500 MG/5ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
	Metformin HCl Tab ER 24HR Osmotic 1000 MG	1000 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
	Metformin HCl Tab ER 24HR Osmotic 500 MG	500 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
Glumetza	Metformin HCl Tab ER 24HR Modified Release 1000 MG	1000 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
			Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
Glumetza	Metformin HCl Tab ER 24HR Modified Release 500 MG	500 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
Metformin hydrochloride	metformin hcl tab	750 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
Metformin hydrochloride	Metformin HCl Tab	625 MG	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods
Riomet	Metformin HCl Oral Soln 500 MG/5ML	500 MG/5ML	Balanced ; Balanced Biosimilar ; Basic ; Basic Annual ; Enhanced ; Enhanced Annual ; HIM Annual 2024 ; HIM Annual 2025 ; HIM Quarterly 2024 ; HIM Quarterly 2025 ; NM HIM Annual 2024 ; NM HIM Annual 2025 ; NM Performance ; Performance ; Performance Annual ; Performance Biosimilar ; Performance Select ; Performance Select Biosimilar ; Whole Foods

PRIOR AUTHORIZATION CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Target Agent(s) will be approved when ALL of the following are met:</p> <ol style="list-style-type: none"> 1. The patient has a diagnosis of type 2 diabetes mellitus AND 2. ONE of the following: <ol style="list-style-type: none"> A. The patient is currently being treated with the requested agent and the patient is currently stable on the requested agent OR B. The patient has tried and had an inadequate response to ONE non-targeted generic metformin product OR C. ONE non-targeted generic metformin product was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse event OR D. The patient has an intolerance, or hypersensitivity to ONE non-targeted generic metformin product that is not expected to occur with the requested agent OR E. The patient has an FDA labeled contraindication to ALL non-targeted generic metformin products that is not expected to occur with the requested agent OR F. ONE non-targeted generic metformin product is 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 OR G. ONE non-targeted generic metformin product is not in the best interest of the patient based on medical necessity OR H. The patient has tried another prescription drug in the same pharmacologic class or with the same mechanism of action as 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 OR I. The requested agent is medically necessary and appropriate for the patient AND 3. The patient does NOT have any FDA labeled contraindication(s) to the requested agent <p>Length of approval: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria.</p> <p>The requested agent will also be approved when the following are met:</p> <ol style="list-style-type: none"> 1. The member resides in Ohio AND 2. The plan is Fully Insured or HIM Shop (SG) AND BOTH of the following <ol style="list-style-type: none"> A. The patient does NOT have any FDA labeled contraindications to the requested agent AND B. ONE of the following: <ol style="list-style-type: none"> 1. The patient has another FDA labeled indication for the requested agent and route of administration OR 2. The patient has another indication that is supported in compendia for the requested agent and route of administration OR

Module	Clinical Criteria for Approval
	<p>3. The prescriber has submitted TWO articles from major peer-reviewed professional medical journals [e.g., Journal of American Medical Association (JAMA), New England Journal of Medicine (NEJM), Lancet] supporting the proposed use(s) as generally safe and effective. Accepted study designs may include, but are not limited to, randomized, double blind, placebo controlled clinical trials. NOTE: Case studies are not acceptable [journal articles required]</p> <p>Non-oncology compendia allowed: DrugDex level 1, 2A or 2B, AHFS-DI (narrative text must be supportive)</p> <p>Oncology compendia allowed: NCCN 1 or 2A, AHFS-DI (narrative text must be supportive), DrugDex level 1, 2A, or 2B, or Clinical Pharmacology (narrative text must be supportive), Lexi-Drugs evidence level A, peer-reviewed medical literature</p> <p>Length of Approval: 12 months</p> <p>NOTE: If Quantity Limit applies, please refer to Quantity Limit Criteria</p>

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication OR B. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND 2. There is support for why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit OR C. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication AND 2. There is support for therapy with a higher dose for the requested indication <p>Length of Approval: 12 months</p>