

HYPOGLYCEMICS, METFORMINS PRIOR AUTHORIZATION FORM

- To review the prior authorization guidelines for Hypoglycemics, Metformins, please refer to the Medical Assistance Prior Authorization of Pharmaceutical Services Handbook Chapter – **Hypoglycemics, Metformins** (accessible at: <http://www.dhs.pa.gov/provider/pharmacyservices/drugsrequiringclinicalpriorauthorization/index.htm>).
- These agents are also subject to quantity limits. If the requested quantity exceeds the limit, please submit supporting chart documentation (refer to **Quantity Limits / Daily Dose Limits** at: <http://www.dhs.pa.gov/provider/pharmacyservices/quantitylimitslist/index.htm>).
- Please submit all requested documentation with this request. Incomplete documentation may delay the processing of this request.**

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
<input type="checkbox"/> New request <input type="checkbox"/> Additional info (PA#: _____) <input type="checkbox"/> Renewal request # of pages in request: _____		Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
RECIPIENT INFORMATION		Street address:	
Recipient Name:		Suite #:	City/state/zip:
Recipient ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:			
<input type="checkbox"/> Fortamet tablet	<input type="checkbox"/> Glucophage XR tablet	<input type="checkbox"/> Glumetza tablet	<input type="checkbox"/> metformin ER tablet (<i>Glumetza ER 500 mg and 1000 mg</i>)
<input type="checkbox"/> Glucophage tablet	<input type="checkbox"/> Glucovance	<input type="checkbox"/> metformin ER tablet (<i>Fortamet 500 mg and 1000 mg</i>)	<input type="checkbox"/> Riomet oral solution
Strength:	Directions:	Quantity:	Refills:
Diagnosis (<i>submit documentation</i>):		Dx code (<i>required</i>):	
1. Has the Recipient tried and failed any of the preferred Hypoglycemics, Metformins? <i>Check all that apply.</i> <input type="checkbox"/> glipizide/metformin tablet <input type="checkbox"/> metformin tablet <input type="checkbox"/> glyburide/metformin tablet <input type="checkbox"/> metformin ER tablet (<i>Glucophage XR 500 mg and 750 mg</i>)		<input type="checkbox"/> Yes – <u>submit all supporting documentation of drug regimen and therapeutic failure.</u> <input type="checkbox"/> No	
2. Does the Recipient have any contraindications or intolerances to any of the preferred agents listed in question (1)?		<input type="checkbox"/> Yes – <u>submit all supporting documentation of medication name(s) and associated intolerances and contraindications.</u> <input type="checkbox"/> No	

PLEASE FAX COMPLETED FORM WITH REQUIRED CLINICAL DOCUMENTATION TO DHS – PHARMACY DIVISION.

Prescriber Signature:	Date:
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