pennsylvania
DEPARTMENT OF HUMAN SERVICES

Office of Medical Assistance Programs
Fee-for-Service, Pharmacy Division
Phone 1-800-537-8862 Fax 1-866-327-0191

HYPOGLYCEMICS, METFORMINS PRIOR AUTHORIZATION FORM

- **Please submit all requested documentation with this form. Incomplete documentation may delay the processing of this request.**
- Prior authorization guidelines for **Hypoglycemics, Metformins** and **Quantity Limits/Daily Dose Limits** are available on the Pharmacy Services website at http://www.dhs.pa.gov/provider/pharmacyservices/index.htm.

PRIOR AUTHORIZATION REQUEST INFORMATION		PRESCRIBER INFORMATION	
☐New request ☐Renewal request	total # of pgs: _____	Prescriber name:	
Name of office contact:		Specialty:	
Contact's phone number:		State license #:	
LTC facility contact/phone:		NPI:	MA Provider ID#:
BENEFICIARY INFORMATION		Street address:	
Beneficiary name:		Suite #:	City/state/zip:
Beneficiary ID#:	DOB:	Phone:	Fax:

CLINICAL INFORMATION

Non-preferred medication requested:

☐Fortamet tablet
☐Glucophage tablet
☐Glucophage XR tablet
☐Glumetza tablet
☐metformin ER tablet *(Fortamet 500 mg and 1000 mg)*
☐metformin ER tablet *(Glumetza ER 500 mg and 1000 mg)*
☐Riomet oral solution
☐_____

Strength:	Directions:	Quantity:	Refills:
Diagnosis *(submit documentation)*:		Dx code (*required*):	

1. Did the beneficiary try and fail any of the preferred Hypoglycemics, Metformins? *Check all that apply.* ☐glipizide/metformin tablet ☐glyburide/metformin tablet ☐metformin tablet ☐metformin ER tablet *(Glucophage XR 500 mg and 750 mg)*	☐Yes – *Submit all supporting documentation of drug regimen and therapeutic failure.* ☐No
2. Does the beneficiary have any contraindications or intolerances to any of the preferred agents listed in question (1)?	☐Yes – *Submit all supporting documentation of medication name(s) and associated intolerances and contraindications.* ☐No

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

Prescriber Signature:	**Date**: