

Prior Authorization Form

GEHA FEDERAL - STANDARD OPTION

Fortamet, Glumetza

This fax machine is located in a secure location as required by HIPAA regulations.  
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.  
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.  
When conditions are met, we will authorize the coverage of Fortamet, Glumetza.

Drug Name (select from list of drugs shown)

Fortamet (metformin extended-release)

Glumetza (metformin extended-release)

Metformin Extended-Release Tablets

Quantity

Frequency

Strength

Route of Administration

Expected Length of Therapy

Patient Information

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Patient Group No.: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Phone: \_\_\_\_\_

Prescribing Physician

Physician Name: \_\_\_\_\_

Physician Phone: \_\_\_\_\_

Physician Fax: \_\_\_\_\_

Physician Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD Code: \_\_\_\_\_

Comments: \_\_\_\_\_

Please circle the appropriate answer for each question.

1. Has the patient experienced an intolerance to generic Glucophage XR?

Y N

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date