Biguanides
Fortamet, Glumetza, Riomet and Riomet ER solution (metformin)
Effective 01/01/2021

Plan	☐ MassHealth ☒ MassHealth (PUF) ☐Commercial/Exchange	**Program Type**	☒ Prior Authorization ☐ Quantity Limit ☐ Step Therapy
Benefit	☒ Pharmacy Benefit ☐ Medical Benefit (NLX)		
Specialty Limitations	N/A		
Contact Information	**Specialty Medications**		
	All Plans	Phone: 866-814-5506	Fax: 866-249-6155
	Non-Specialty Medications		
	MassHealth	Phone: 877-433-7643	Fax: 866-255-7569
	Commercial	Phone: 800-294-5979	Fax: 888-836-0730
	Exchange	Phone: 855-582-2022	Fax: 855-245-2134
	Medical Specialty Medications (NLX)		
	All Plans	Phone: 844-345-2803	Fax: 844-851-0882
Exceptions	N/A		

Overview

Metformin is an antihyperglycemic agent which improves glucose tolerance in patients with type 2 diabetes mellitus, lowering both basal and postprandial plasma glucose. Metformin decreases hepatic glucose production, decreases intestinal absorption of glucose, and improves insulin sensitivity by increasing peripheral glucose uptake and utilization. With metformin therapy, insulin secretion remains unchanged while fasting insulin levels and day-long plasma insulin response may decrease.

No PA	PA required
Glucophage® # (metformin)	Fortamet® (metformin extended release) *
Glucophage® XR # (metformin extended release)	Glumetza® (metformin extended release) *
Riomet® # (metformin solution) < 13 years old §	Riomet® (metformin solution) ≥ 13 years old §
	Riomet ER® (metformin solution extended release)
	metformin ER Osmotic (Fortamet)
	metformin ER (Glumetza)

This is a brand-name drug with FDA "A"-rated generic equivalents. PA is required for the brand, unless a particular form of that drug (for example, tablet, capsule, or liquid) does not have an FDA "A"-rated generic equivalent.
*A-rated generic available. Both brand and A-rated generic require PA.
§ Brand Preferred over generic equivalents. A trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

Coverage Guidelines

Fortamet and Glumetza

Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with Fortamet or Glumetza, excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted if the member meets ALL following criteria and documentation has been submitted:

1. The member has a diagnosis of Type 2 Diabetes Mellitus
2. Medical records documenting an inadequate response or adverse reaction to generic extended-release metformin (must be generic Glucophage XR 500mg or Glucophage XR 750mg) at the requested dose for at least 90 days.
3. For metformin extended release (Glumetza®): clinical rationale for the use of this product instead of other available metformin formulations
4. If request is for BRAND NAME Fortamet® or Glumetza®, the member must meet the above criteria and the prescriber must provide medical records documenting an inadequate response or adverse reaction to generic metformin extended release

Riomet and Riomet ER Solution

Authorization may be reviewed on a case by case basis for members new to AllWays Health Partners who are currently receiving treatment with Riomet or Riomet ER solution excluding when the product is obtained as samples or via manufacturer's patient assistance programs

OR

Authorization may be granted if the member meets all following criteria and documentation has been submitted:

1. Member has a diagnosis of type 2 Diabetes Mellitus
2. Member meets **ONE** of the following:
    a. Medical necessity for a liquid formulation (inability to swallow oral medications)
    b. Medical records documenting an inadequate response despite 90 days of therapy with the metformin tablet formulation, or an allergic reaction or adverse reaction to the metformin tablet formulation that is not class specific (i.e. nausea, diarrhea)
3. If the request is for Riomet ER®, medical records documenting an inadequate response despite 90 days of therapy with the immediate release metformin solution formulation

Continuation of Therapy

Reauthorization requires physician attestation of continuation of therapy.

Limitations

Initial approvals and reauthorizations will be granted for 12 months

§Brand preferred over generic equivalent:

A trial of the preferred drug or clinical rationale for prescribing the non-preferred drug generic equivalent.

- Riomet solution

References

1. Fortamet (metformin) [prescribing information]. Florham Park, NJ: Shionogi; November 2018.
2. Glumetza (metformin) [prescribing information]. Bridgewater, NJ: Salix Pharmaceuticals; October 2019.

3. Glumetza (metformin) [product monograph]. Montreal, Quebec, Canada: Valeant Canada; June 2012.
4. Riomet ER (metformin) suspension [prescribing information]. Cranbury, NJ: Sun Pharmaceuticals; September 2019.
5. Riomet (metformin) [prescribing information]. Cranbury, NJ: Sun Pharmaceuticals; November 2018.

Review History

07/01/2017 – Effective
04/24/2018 – Reviewed
04/17/2019 – Reviewed in P&T Meeting
05/20/2020 – Added Riomet ER solution formulation. Effective 7/1/2020
11/05/2020 – Updated; Changed criteria name to Biguanide and combination products; Updated criteria to be in compliance with MassHealth partial unified formulary requirements for implementation on 1/1/2021

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