



Kansas Medical Assistance Program

P O Box 3571
Topeka, KS 66601-3571
Provider 1-800-933-6593
Beneficiary 1-800-766-9012

Prior Authorization for Non-Preferred Biguanides

Preferred	Non-Preferred, Prior Authorization Required
Glucophage® (metformin) Glucophage® XR (metformin ER)	Fortamet® (metformin ER) Glumetza® (metformin ER) Riomet® (metformin oral solution)

Beneficiary Information

Name: _____

Medicaid ID #: _____ Date of Birth: _____

Pharmacy Information

Name: _____ Medicaid ID #: _____

NPI #: _____ Phone #: _____ Fax #: _____

Requested Drug: _____ NDC: _____

Prescriber Information

Name: _____ Medicaid ID #: _____

NPI #: _____ Phone #: _____ Fax #: _____

Please check the appropriate box and provide required information to receive the requested non-preferred drug.

Patient has a medical intolerance to preferred drug. Please provide the name of the preferred drug and clinical symptoms of intolerance experienced by the patient: _____

Patient has had an inadequate response to preferred drug. Name of preferred agent patient tried: _____

An appropriate formulation or indication is not available as a preferred drug. Please specify which formulation or indication is needed and information supporting the need: _____

Prescriber's Signature: _____ **Date:** _____

The completed form should be faxed to the HP Prior Authorization Unit at 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.