

## **Clinical Policy: Metformin ER (Glumetza, Fortamet)**

Reference Number: CP.PMN.72

Effective Date: 11.01.15

Last Review Date: 05.18

Line of Business: Commercial, Medicaid

[Revision Log](#)

See [Important Reminder](#) at the end of this policy for important regulatory and legal information.

### **Description**

Metformin extended-release [ER] (Glumetza<sup>®</sup>, Fortamet<sup>®</sup>) is an oral biguanide antidiabetic agent.

### **FDA Approved Indication(s)**

Glumetza and Fortamet are indicated as an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus (DM).

Limitation(s) of use: Glumetza should not be used in patients with type 1 DM or for the treatment of diabetic ketoacidosis, as it would not be effective in these settings.

### **Policy/Criteria**

*Provider must submit documentation (such as office chart notes, lab results or other clinical information) supporting that member has met all approval criteria.*

It is the policy of health plans affiliated with Centene Corporation<sup>®</sup> that Glumetza and Fortamet are **medically necessary** when the following criteria are met:

#### **I. Initial Approval Criteria**

##### **A. Type 2 Diabetes Mellitus (must meet all):**

1. Diagnosis of type 2 DM;
2. Member has experienced clinically significant adverse effects to immediate-release metformin or has contraindication(s) to its excipients;
3. Member has experienced clinically significant adverse effects to extended-release metformin (Glucophage<sup>®</sup> XR) or has contraindication(s) to its excipients;
4. If request is for brand Glumetza/Fortamet, member has experienced clinically significant adverse effects to generic Glumetza/Fortamet or has contraindication(s) to its excipients;
5. Dose does not exceed 2000 mg/day.

##### **Approval duration:**

**Medicaid** -12 months

**Commercial** - Length of Benefit

##### **B. Other diagnoses/indications**

1. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

**II. Continued Therapy**

**A. Type 2 Diabetes Mellitus** (must meet all):

1. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed 2000 mg/day.

**Approval duration:**

**Medicaid** - 12 months

**Commercial** - Length of Benefit

**B. Other diagnoses/indications** (must meet 1 or 2):

1. Currently receiving medication via Centene benefit and documentation supports positive response to therapy.

**Approval duration: Duration of request or 12 months (whichever is less);** or

2. Refer to the off-label use policy for the relevant line of business if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized): CP.CPA.09 for commercial and CP.PMN.53 for Medicaid.

**III. Diagnoses/Indications for which coverage is NOT authorized:**

- A.** Non-FDA approved indications, which are not addressed in this policy, unless there is sufficient documentation of efficacy and safety according to the off label use policies – CP.CPA.09 for commercial and CP.PMN.53 for Medicaid or evidence of coverage documents;
- B.** Type 1 DM;
- C.** Diabetic ketoacidosis.

**IV. Appendices/General Information**

*Appendix A: Abbreviation/Acronym Key*

DM: diabetes mellitus

ER: extended-release

FDA: Food and Drug Administration

GPI: generic product identifier

*Appendix B: Therapeutic Alternatives*

*This table provides a listing of preferred alternative therapy recommended in the approval criteria. The drugs listed here may not be a formulary agent for all relevant lines of business and may require prior authorization.*

<b>Drug Name</b>	<b>Dosing Regimen</b>	<b>Dose Limit/ Maximum Dose</b>
metformin (Glucophage®)	500 mg PO twice daily or 850 mg PO once daily, given with meals. Dosage increases should be made in increments of 500 mg weekly or 850 mg every 2 weeks, up to 2000 mg/day PO, given in divided doses	2550 mg/day
metformin ER (Glucophage® XR)	Glucophage XR: 500 mg PO once daily with the evening meal; may increase daily dose by 500 mg/week as needed	Glucophage XR: 2000 mg/day

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
	Fortamet: 1000 mg PO once daily; may titrate in increments of no more than 500 mg/week	Fortamet: 2500 mg/day

*Therapeutic alternatives are listed as Brand name® (generic) when the drug is available by brand name only and generic (Brand name®) when the drug is available by both brand and generic.*

*Appendix C: General Information*

- Generic Glucophage XR (GPI 27250050007520 or 27250050007530) and generic Fortamet (GPI 27250050007560 or 27250050007570) are identified with different GPI 14.
- Glucophage XR uses dual hydrophilic polymer matrix systems, Fortamet uses single-composition osmotic technology, and Glumetza uses gastric retention technology.

**V. Dosage and Administration**

Indication	Dosing Regimen	Maximum Dose
Type 2 DM	500 mg PO QD with the evening meal; may increase the dose in 500 mg increments every 1-2 weeks as needed	2000 mg/day

**VI. Product Availability**

Extended-release tablets: 500 mg and 1000 mg

**VII. References**

1. Glumetza Prescribing Information. Bridgewater, NJ: Valeant Pharmaceuticals North America LLC; April 2017. Available at: <https://shared.salix.com/shared/pi/glumetza-pi.pdf>. Accessed January 17, 2018.
2. Fortamet Prescribing Information. Fort Lauderdale, FL: Actavis Laboratories TL, Inc.; April 2017. Accessed May 10, 2018.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2017. Available at: <http://www.clinicalpharmacology-ip.com/>. Accessed January 17, 2018.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
New guideline created	11.15	11.15
Converted to new integrated template. Added requirement for PDL immediate release metformin. Added FDA max recommended dose and health plan approved QL statement. Updated continuation criteria. Updated references to reflect current literature search.	08.16	11.16
Converted to new template. Initial: Added requirement related to contraindications per PI (severe renal impairment) in accordance with safety approach.	08.14.17	11.17

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Continued approval: Added requirement that member is responding positively to therapy. Updated references.		
2Q 2018 annual review: no significant changes from previously approved corporate policy, policies combined for Centene Medicaid and Commercial lines of business; added that members requesting brand Glumetza must have contraindication or intolerance to generic Glumetza; Medicaid: removed age limit and contraindication since other formulations of metformin are available freely on PDL without such restrictions; increased initial approval duration from 3 months to 12 months; Commercial: modified “failure” to allow only contraindication or clinically significant adverse effects; added requirement for positive response to therapy for continued therapy requests; references reviewed and updated.	02.27.18	05.18
Per SDC: added Fortamet to policy, removed redirection to generic Fortamet.	06.14.18	

**Important Reminder**

This clinical policy has been developed by appropriately experienced and licensed health care professionals based on a review and consideration of currently available generally accepted standards of medical practice; peer-reviewed medical literature; government agency/program approval status; evidence-based guidelines and positions of leading national health professional organizations; views of physicians practicing in relevant clinical areas affected by this clinical policy; and other available clinical information. The Health Plan makes no representations and accepts no liability with respect to the content of any external information used or relied upon in developing this clinical policy. This clinical policy is consistent with standards of medical practice current at the time that this clinical policy was approved. “Health Plan” means a health plan that has adopted this clinical policy and that is operated or administered, in whole or in part, by Centene Management Company, LLC, or any of such health plan’s affiliates, as applicable.

The purpose of this clinical policy is to provide a guide to medical necessity, which is a component of the guidelines used to assist in making coverage decisions and administering benefits. It does not constitute a contract or guarantee regarding payment or results. Coverage decisions and the administration of benefits are subject to all terms, conditions, exclusions and limitations of the coverage documents (e.g., evidence of coverage, certificate of coverage, policy, contract of insurance, etc.), as well as to state and federal requirements and applicable Health Plan-level administrative policies and procedures.

This clinical policy is effective as of the date determined by the Health Plan. The date of posting may not be the effective date of this clinical policy. This clinical policy may be subject to applicable legal and regulatory requirements relating to provider notification. If there is a discrepancy between the effective date of this clinical policy and any applicable legal or regulatory requirement, the requirements of law and regulation shall govern. The Health Plan

retains the right to change, amend or withdraw this clinical policy, and additional clinical policies may be developed and adopted as needed, at any time.

This clinical policy does not constitute medical advice, medical treatment or medical care. It is not intended to dictate to providers how to practice medicine. Providers are expected to exercise professional medical judgment in providing the most appropriate care, and are solely responsible for the medical advice and treatment of members. This clinical policy is not intended to recommend treatment for members. Members should consult with their treating physician in connection with diagnosis and treatment decisions.

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**Note:**

**For Medicaid members**, when state Medicaid coverage provisions conflict with the coverage provisions in this clinical policy, state Medicaid coverage provisions take precedence. Please refer to the state Medicaid manual for any coverage provisions pertaining to this clinical policy.

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