



Metformin/Glipizide

**Express Scripts
Prior Authorization
Phone 800-417-8164
Fax 877-837-5922**

Please have the information below ready when calling in the authorization.

Member's Last Name	Member's First Name
VH ID number	Date of Birth
Prescriber's Name	Contact Person
Office phone	Office Fax

Medication:	Diagnosis:
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1. Does the patient have a functioning transplanted kidney?
2. Does the patient have a serum creatinine 1.4 mg/dL or higher in females or 1.5 mg/dL or higher in males?
3. Are there any other comments, diagnoses, symptoms, relevant lab values, and/or additional pertinent information that you feel is important to this review?

Notice: **Failure to provide all information requested on this form may result in delayed processing or an adverse determination for insufficient information.** Our response time for prescription drug coverage requests is 72 hours. View our formulary and Prior Authorization forms online at <http://www.scanhealthplan.com>.