



Metformin/Glyburide

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

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

Last Name	First Name
VH ID number	Date of Birth
Doctor's Name	Phone number

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>.