Clinical Policy: Metformin ER (Fortamet, Glumetza)

Reference Number: ERX.NPA.43
Effective Date: 12.01.15
Last Review Date: 02.22
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] (Fortamet®, Glumetza®) is an oral biguanide antidiabetic agent.

FDA Approved Indication(s)

Fortamet and Glumetza 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: Fortamet and Glumetza should not be used in patients with type 1 DM or for the treatment of diabetic ketoacidosis, as they 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.

Health plan approved formularies should be reviewed for all coverage determinations. Requirements to use preferred alternative agents apply only when such requirements align with the health plan approved formulary.

It is the policy of health plans affiliated with Envolve Pharmacy Solutions™ that Fortamet and Glumetza 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 tablets (Glucophage® XR) or has contraindication(s) to its excipients;
4. If request is for brand Fortamet/Glumetza, member has experienced clinically significant adverse effects to generic Fortamet/Glumetza or has contraindication(s) to its excipients;
5. Dose does not exceed 2,000 mg (2 tablets) per day.

Approval duration: 12 months

B. Other diagnoses/indications

1. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

II. Continued Therapy

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

1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions 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 2,000 mg (2 tablets) per day.

Approval duration: 12 months

B. Other diagnoses/indications (must meet 1 or 2)**:**
1. Currently receiving medication via a health plan affiliated with Envolve Pharmacy Solutions and documentation supports positive response to therapy.
   Approval duration: Duration of request or 12 months (whichever is less); or
2. Refer to ERX.PA.01 if diagnosis is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized).

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 policy – ERX.PA.01 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 and may require prior authorization.

Drug Name	Dosing Regimen	Dose Limit/ Maximum Dose
metformin (Glucophage®)	500 mg PO BID or 850 mg PO QD, given with meals. Dosage increases should be made in increments of 500 mg weekly or 850 mg every 2 weeks, up to 2,000 mg/day PO, given in divided doses	2,550 mg/day
metformin ER (Glucophage® XR)	500 mg PO QD with the evening meal; may increase daily dose by 500 mg/week as needed	2,000 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: Contraindications/Boxed Warnings

- Contraindication(s): severe renal impairment (eGFR < 30 mL/min/1.73 m^2); known hypersensitivity to metformin; acute or chronic metabolic acidosis, including diabetic ketoacidosis, with or without coma
- Boxed warning(s): lactic acidosis

Appendix D: General Information

- Generic Glucophage XR (GPI 27250050007520 or 27250050007530), generic Fortamet (GPI 27250050007560 or 27250050007570), and generic Glumetza (GPI 27250050007580 or 27250050007590) 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

Drug Name	Dosing Regimen	Maximum Dose
Metformin ER (Fortamet)	500 mg PO QD; may titrate in increments of no more than 500 mg/week If glycemic control is not achieved with 2,000 mg PO QD, consider a trial of 1,000 mg PO BID	2,000 mg/day
Metformin ER (Glumetza)	500 mg PO QD with the evening meal; may increase the dose in 500 mg increments every 1-2 weeks	2,000 mg/day

VI. Product Availability

Drug Name	Product Availability
Metformin ER (Fortamet)	Extended-release tablets: 500 mg, 1,000 mg
Metformin ER (Glumetza)	Extended-release tablets: 500 mg, 1,000 mg

VII. References

1. Glumetza Prescribing Information. Bridgewater, NJ: Salix Pharmaceuticals; August 2019. Available at: https://shared.salix.com/shared/pi/glumetza-pi.pdf. Accessed September 16, 2021.
2. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2021. Available at: http://www.clinicalpharmacology-ip.com. Accessed September 16, 2021.
3. Fortamet Prescribing Information. Fort Lauderdale, FL: Actavis Laboratories FL, Inc.; November 2018. Available at: https://www.shionogi.com/wp-content/themes/pdfs/fortamet.pdf. Accessed September 16, 2021.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
2Q 2018 annual review: Removed age limit and contraindication since other formulations of metformin are available freely on PDL without such restrictions. Added that members requesting brand Glumetza must have contraindication/intolerance to generic Glumetza. References reviewed and updated.	02.27.18	05.18
1Q 2019 annual review: added Fortamet to policy and removed re-direction to generic Fortamet; references reviewed and updated.	09.27.18	02.19
1Q 2020 annual review: no significant changes; modified max dose to 2,000 mg (2 tablets) per day for both products per prescribing information; references reviewed and updated.	09.24.19	02.20
1Q 2021 annual review: no significant changes; references reviewed and updated.	10.26.20	02.21
1Q 2022 annual review: no significant changes; references reviewed and updated.	09.16.21	02.22

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.

This Clinical Policy is not intended to dictate to providers how to practice medicine, nor does it constitute a contract or guarantee regarding payment or results. 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.