Clinical Policy: Metformin ER (Fortamet, Glumetza)

Reference Number: CP.PMN.72
Effective Date: 12.01.15
Last Review Date: 02.24
Line of Business: Commercial, HIM, 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.

It is the policy of health plans affiliated with Centene Corporation® 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 (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 any of the following (a and b):
   a. 2,000 mg per day;
   b. 2 tablets per day.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or
2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, and CP.PMN.53 for Medicaid.

II. Continued Therapy

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

1. Member meets one of the following (a or b):
   a. Currently receiving medication via Centene benefit or member has previously met initial approval criteria;
   b. Member is currently receiving medication and is enrolled in a state and product with continuity of care regulations (*refer to state specific addendums for CC.PHARM.03A and CC.PHARM.03B);*
2. Member is responding positively to therapy;
3. If request is for a dose increase, new dose does not exceed any of the following (a and b):
   a. 2,000 mg per day;
   b. 2 tablets per day.

Approval duration:
Medicaid/HIM – 12 months
Commercial – 12 months or duration of request, whichever is less

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

1. If this drug has recently (within the last 6 months) undergone a label change (e.g., newly approved indication, age expansion, new dosing regimen) that is not yet reflected in this policy, refer to one of the following policies (a or b):
   a. For drugs on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the no coverage criteria policy for the relevant line of business: CP.CPA.190 for commercial, HIM.PA.33 for health insurance marketplace, and CP.PMN.255 for Medicaid; or
   b. For drugs NOT on the formulary (commercial, health insurance marketplace) or PDL (Medicaid), the non-formulary policy for the relevant line of business:

CP.CPA.190 for commercial, HIM.PA.103 for health insurance marketplace, and CP.PMN.16 for Medicaid; or

2. If the requested use (e.g., diagnosis, age, dosing regimen) is NOT specifically listed under section III (Diagnoses/Indications for which coverage is NOT authorized) AND criterion 1 above does not apply, refer to the off-label use policy for the relevant line of business: CP.CPA.09 for commercial, HIM.PA.154 for health insurance marketplace, 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, HIM.PA.154 for health insurance marketplace, 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.

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 2000 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

Indication	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://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=fb832474-88d9-4e29-95cd-fbc446944cc4. Accessed October 18, 2023.
2. Fortamet Prescribing Information. Fort Lauderdale, FL: Actavis Laboratories TL, Inc.; November 2018. Available at: https://www.shionogi.com/wp-content/themes/pdfs/fortamet.pdf. Accessed October 18, 2023.
3. Clinical Pharmacology [database online]. Tampa, FL: Gold Standard, Inc.; 2023. Available at: https://www.clinicalkey.com/pharmacology/. Accessed October 18, 2023.

Reviews, Revisions, and Approvals	Date	P&T Approval Date
1Q 2020 annual review: added HIM line of business; 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 to HIM.PHAR.21 revised to HIM.PA.154; 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

Reviews, Revisions, and Approvals	Date	P&T Approval Date
Revised approval duration for Commercial line of business from length of benefit to 12 months or duration of request, whichever is less.	04.27.22	08.22
Template changes applied to other diagnoses/indications and continued therapy section.	10.10.22	
1Q 2023 annual review: no significant changes; references reviewed and updated.	10.27.22	02.23
1Q 2024 annual review: no significant changes; references reviewed and updated.	10.18.23	02.24

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.

Providers referred to in this clinical policy are independent contractors who exercise independent judgment and over whom the Health Plan has no control or right of control. Providers are not agents or employees of the Health Plan.

This clinical policy is the property of the Health Plan. Unauthorized copying, use, and distribution of this clinical policy or any information contained herein are strictly prohibited. Providers, members and their representatives are bound to the terms and conditions expressed herein through the terms of their contracts. Where no such contract exists, providers, members and their representatives agree to be bound by such terms and conditions by providing services to members and/or submitting claims for payment for such services.

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.