Cigna National Formulary Coverage Policy

Drug Quantity Management – Per Rx
Diabetes – Metformin Extended-Release

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Product Identifier(s)

Effective 1/1/23 to 2/27/23: 111158

Effective 2/28/23: 59855

INSTRUCTIONS FOR USE
The following Coverage Policy applies to health benefit plans administered by Cigna Companies. Certain Cigna Companies and/or lines of business only provide utilization review services to clients and do not make coverage determinations. References to standard benefit plan language and coverage determinations do not apply to those clients. Coverage Policies are intended to provide guidance in interpreting certain standard benefit plans administered by Cigna Companies. Please note, the terms of a customer's particular benefit plan document [Group Service Agreement, Evidence of Coverage, Certificate of Coverage, Summary Plan Description (SPD) or similar plan document] may differ significantly from the standard benefit plans upon which these Coverage Policies are based. For example, a customer's benefit plan document may contain a specific exclusion related to a topic addressed in a Coverage Policy. In the event of a conflict, a customer's benefit plan document always supersedes the information in the Coverage Policies. In the absence of a controlling federal or state coverage mandate, benefits are ultimately determined by the terms of the applicable benefit plan document. Coverage determinations in each specific instance require consideration of 1) the terms of the applicable benefit plan document in effect on the date of service; 2) any applicable laws/regulations; 3) any relevant collateral source materials including Coverage Policies and; 4) the specific facts of the particular situation. Coverage Policies relate exclusively to the administration of health benefit plans. Coverage Policies are not recommendations for treatment and should never be used as treatment guidelines. In certain markets, delegated vendor guidelines may be used to support medical necessity and other coverage determinations.

National Formulary Medical Necessity

Drugs Affected

- Fortamet® (metformin extended-release tablets – generic [brand obsolete])
- metformin HCl extended-release tablets (generic only)
- Glumetza® (metformin extended-release tablets – generic)

This Drug Quantity Management program has been developed to promote the safe, effective, and economic use of extended-release metformin. If the Drug Quantity Management rule is not met for the requested medication at the point of service, coverage will be determined by the Criteria below. All approvals are provided for 1 year in duration.

Drug Quantity Limits

Product	Strength/Dosage Form	Maximum Quantity per Rx
Fortamet® (metformin extended-release tablets, generic [brand obsolete])	500 mg tablets	30 tablets
	1,000 mg tablets	60 tablets
Glucophage XR (metformin HCl extended-release tablets – Bristol-Myers Squibb, generic [brand obsolete])	500 mg tablets	120 tablets
	750 mg tablets	60 tablets
Glumetza® (metformin extended-release tablets, generic)	500 mg tablets	120 tablets
	1,000 mg tablets	60 tablets

Criteria

Cigna covers quantities as medically necessary when the following criteria are met:

Metformin 500 mg extended-release tablets (Fortamet, generic [brand no longer available])

1. If the individual is taking 1,500 mg per day, approve 90 tablets per dispensing.
   Note: At a dose of 1,500 mg per day, 90 of the 500 mg tablets is a quantity sufficient to allow for a 30-day supply per dispensing. If the individual is taking a dose of 1,000 mg or 2,000 mg daily, they should be referred to the 1,000 mg tablet. If a higher dose of metformin is required, metformin immediate-release tablets should be used.

Metformin 1,000 mg extended-release tablets (Fortamet, generic [brand no longer available])
No overrides recommended.

Metformin 500 mg and 750 mg extended-release tablets (generic to formerly available Glucophage XR)
No overrides recommended.

Metformin 500 mg and 1,000 mg extended-release tablets (Glumetza, generic)
No overrides recommended.

Conditions Not Covered

Any other exception is considered not medically necessary.

References

1. Fortamet® extended-release tablets [prescribing information]. Florham Park, NJ: Shionogi; March 2021.
2. Glucophage® tablets/Glucophage® XR extended-release tablets [prescribing information]. Princeton, NJ: Bristol-Myers Squibb; May 2018.
3. Glumetza® extended-release tablets [prescribing information]. Bridgewater, NJ: Salix; August 2019.

Revision History

Type of Revision	Summary of Changes	Approval Date
Annual Revision	Approval duration was changed from 3 years to 1 year. Brand Glucophage XR removed from policy (obsolete).	06/29/2022