



Metformin ER Quantity Limit Program Summary

Quantity limits apply to Medicaid.

POLICY REVIEW CYCLE

Effective Date
05-01-2024

Date of Origin
10-01-2016

FDA APPROVED INDICATIONS AND DOSAGE

See package insert for FDA prescribing information: <https://dailymed.nlm.nih.gov/dailymed/index.cfm>

POLICY AGENT SUMMARY QUANTITY LIMIT

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	QL Amount	Dose Form	Day Supply	Duration	Addtl QL Info	Allowed Exceptions	Targeted NDCs When Exclusions Exist
	metformin HCl Tab ER 24HR 500 MG	500 MG	120	Tablets	30	DAYS			
	metformin HCl Tab ER 24HR 750 MG	750 MG	60	Tablets	30	DAYS			
	metformin HCl Tab ER 24HR Osmotic 1000 MG	1000 MG	60	Tablets	30	DAYS			
	metformin HCl Tab ER 24HR Osmotic 500 MG	500 MG	90	Tablets	30	DAYS			
Glumetza	Metformin HCl Tab ER 24HR Modified Release 1000 MG	1000 MG	60	Tablets	30	DAYS			
Glumetza	Metformin HCl Tab ER 24HR Modified Release 500 MG	500 MG	90	Tablets	30	DAYS			

CLIENT SUMMARY – QUANTITY LIMITS

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
	metformin HCl Tab ER 24HR 500 MG	500 MG	Medicaid
	metformin HCl Tab ER 24HR 750 MG	750 MG	Medicaid
	metformin HCl Tab ER 24HR Osmotic 1000 MG	1000 MG	Medicaid
	metformin HCl Tab ER 24HR Osmotic 500 MG	500 MG	Medicaid

Target Brand Agent Name(s)	Target Generic Agent Name(s)	Strength	Client Formulary
Glumetza	Metformin HCl Tab ER 24HR Modified Release 1000 MG	1000 MG	Medicaid
Glumetza	Metformin HCl Tab ER 24HR Modified Release 500 MG	500 MG	Medicaid

QUANTITY LIMIT CLINICAL CRITERIA FOR APPROVAL

Module	Clinical Criteria for Approval
	<p>Quantity Limit for the Target Agent(s) will be approved when ONE of the following is met:</p> <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the program quantity limit OR 2. The requested quantity (dose) exceeds the program quantity limit AND ONE of the following: <ol style="list-style-type: none"> A. BOTH of the following: <ol style="list-style-type: none"> 1. The requested agent does NOT have a maximum FDA labeled dose for the requested indication AND 2. Information has been provided to support therapy with a higher dose for the requested indication OR B. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) does NOT exceed the maximum FDA labeled dose for the requested indication AND 2. Information has been provided to support why the requested quantity (dose) cannot be achieved with a lower quantity of a higher strength that does NOT exceed the program quantity limit OR C. BOTH of the following: <ol style="list-style-type: none"> 1. The requested quantity (dose) exceeds the maximum FDA labeled dose for the requested indication AND 2. Information has been provided to support therapy with a higher dose for the requested indication <p>Length of Approval: up to 12 months</p>