PRIOR AUTHORIZATION REQUEST
Engrifta

PATIENT: Name_____
Address: _____
City, State, Zip_____
D.O.B. _____
Member ID:_____

Prescriber: Name_____
Address _____
City, State, Zip_____
Phone _____
Fax _____
NPI _____

Medication Requested: *Engrifta* **Qty Requested: _____**

Your patient's prescription benefit requires that we review certain requests for coverage with the prescriber. You have prescribed a medication for your patient that requires Prior Authorization before benefit coverage or coverage of additional quantities can be provided. Please complete the following questions then fax this form to the toll free number listed below. Upon receipt of the completed form, prescription benefit coverage will be determined based on the plan's rules.

SECTION A Please answer the following questions

1. Is this a request for INITIAL or CONTINUATION of therapy with the requested medication?
   - ❑ INITIAL → ***please answer questions 2 – 8***
   - ❑ CONTINUATION → ***please answer question 9***
2. ❑Yes ❑No Is the patient currently pregnant?
3. ❑Yes ❑No Is the patient using a reliable form of birth control (pregnancy category X)?
4. ❑Yes ❑No Does the patient have an active neoplastic disease or acute critical illness?
5. ❑Yes ❑No Does the patient have disruption of the hypothalamic-pituitary axis (for example, hypothalamic-pituitary-adrenal (HPA) suppression) due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, radiation therapy of the head or head trauma?
6. ❑Yes ❑No Is the patient at risk for medical complications due to excess abdominal fat?
7. What is the diagnosis or indication?
   - ❑ Excess abdominal fat due to lipodystrophy
   - ❑ Weight Loss
   - ❑ All other indications or diagnoses ***(please specify)***_____
8. ❑Yes ❑No Does the patient have HIV?
9. ❑Yes ❑No Is there documentation to confirm that the patient has shown a clinical response with the requested medication?

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If you have any questions, call: 800-753-2851

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Please document the diagnoses, symptoms, and/or any other information important to this review:

SECTION B Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 877-251-5896

If you have any questions, call: 800-753-2851