



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

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Disclaimer: An authorization is not a guarantee of payment. Member must be eligible at the time services are rendered. Services must be a covered Health Plan Benefit and medically necessary with prior authorization as per Plan policy and procedures.

Confidentiality: The information contained in this transmission is confidential and may be protected under the Health Insurance Portability and Accountability Act of 1996. If you are not the intended recipient any use, distribution, or copying is strictly prohibited. If you have received this facsimile in error, please notify us immediately and destroy this document.

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questions, call:
800-753-2851