maryland physicians care
Medicaid with a Heart

PRIOR AUTHORIZATION REQUEST

Myalept

Patient Information:

Name:	
Member ID:	
Address:	
City, State, Zip:	
Date of Birth:	

Prescriber Information:

Name:	
NPI:	
Phone Number:	
Fax Number	
Address:	
City, State, Zip:	

Requested Medication

Rx Name:	
Rx Strength	
Rx Quantity:	
Rx Frequency:	
Rx Route of Administration:	
Diagnosis and ICD Code:	

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 note that supporting clinical documentation is required for **ALL** PA requests.

1 What is the diagnosis or indication?

[] Generalized Lipodystrophy (Congenital or Acquired) (If checked, go to 2)

[] General Obesity not associated with Congenital Leptin Deficiency (If checked, no further questions)

[] Human Immunodeficiency Virus (HIV)-related Lipodystrophy (If checked, no further questions)

[] Partial Lipodystrophy (If checked, no further questions)

[] Other (If checked, no further questions)

If you have any questions, call: 1-888-258-8250

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2	Is the requested medication prescribed by an endocrinologist? [If no, no further questions.]	Yes	No
3	Are the prescriber and patient enrolled in the Myalept REMS program? [If no, no further questions.]	Yes	No
4	Is the patient currently receiving the requested medication? [If no, skip to question 8.]	Yes	No
5	Has the patient been receiving medication samples for the requested medication? [If yes, skip to question 8.]	Yes	No
6	Does the patient have a previously approved prior authorization (PA) on file with the current plan? [Note: If the patient does NOT have a previously approved PA on file for the requested medication with the current plan, the renewal request will be considered under initial therapy.] [If no, skip to question 8.]	Yes	No
7	Has documentation been provided to confirm that there is clinical response for the patient with improvement in at least one category from baseline: A) HbA1c; B) Triglycerides; C) Fasting insulin? ACTION REQUIRED: Submit supporting documentation. [No further questions.]	Yes	No
8	Does the patient have a confirmed documented diagnosis of congenital or acquired generalized lipodystrophy associated with leptin deficiency? [If no, no further questions.]	Yes	No
9	Does the prescriber attest that the requested medication will be used as an adjunct to diet modification? [If no, no further questions.]	Yes	No
10	Has documentation been provided to confirm that the patient has Diabetes Mellitus with HbA1c GREATER THAN 7% AND is on maximally tolerated insulin therapy? ACTION REQUIRED: Submit supporting documentation. [If yes, no further questions.]	Yes	No
11	Has documentation been provided to confirm that the patient has hypertriglyceridemia with triglyceride (TG) GREATER THAN 250 mg/dL AND is on maximally tolerated triglyceride lowering agents from two different classes (fibrates, statins)? ACTION REQUIRED: Submit supporting documentation.	Yes	No

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

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SECTION B: Physician Signature

PHYSICIAN SIGNATURE DATE

FAX COMPLETED FORM TO: 1-833-896-0656

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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