



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. Pharmacy prior authorization reviews can be subject to trial with additional medications that are not listed within the criteria. The policies are subject to change based on COMAR requirements, MDH transmittals and updates to treatment guidelines.

1	What is the diagnosis or indication? <input type="checkbox"/> Generalized Lipodystrophy (Congenital or Acquired) (If checked, go to 2) <input type="checkbox"/> General Obesity not associated with Congenital Leptin Deficiency (If checked, no further questions) <input type="checkbox"/> Human Immunodeficiency Virus (HIV)-related Lipodystrophy (If checked, no further questions) <input type="checkbox"/> Partial Lipodystrophy (If checked, no further questions)
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**If you have any questions, call:
1-888-258-8250**

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Other (If checked, no further questions)

- | | | | |
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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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