OPTIMA HEALTH COMMUNITY CARE
AND
OPTIMA FAMILY CARE
(MEDICAID)

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-800-750-9692**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **Incomplete form will delay authorization process.**

Drug Requested: **Myalept**® (metreleptin)

DRUG INFORMATION: Complete information below or authorization process will be delayed

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

CLINICAL CRITERIA: **ALL** boxes below **must** be checked to qualify to ensure authorization will **NOT** be delayed. Lab results and chart notes **MUST** be attached**.**

For Initiation and Continuation of Treatment - check **ALL** boxes that apply**.**

- ❑ Patient has a leptin deficiency as defined as **(a copy of fasting laboratory leptin assay results is required for approval):**
  - ❑ <4.0 ng/mL fasting leptin for females
  - ❑ <3.0 ng/mL fasting leptin for males
- ❑ Patient has a diagnosis of **(choose indication):**
  - ❑ Acquired generalized lipodystrophy
  - ❑ Congenital generalized lipodystrophy
- ❑ Patient has a concurrent condition of **(check all that apply)**:
  - ❑ Diabetes mellitus or insulin resistance and has failed 30 day trial of **(please submit chart notes to document)**:
    - ❑ Metformin, total daily dose of _____

      AND
    - ❑ High-dose insulin or insulin pump
  - ❑ Hypertriglyceridemia and has failed 30 day trial of **(please submit chart notes to document)**:
    - ❑ Low-fat diet and/or dietary restrictions

      AND

(Continued on next page)

- ❑ Fenofibrate or fenofibrate derivative

OR

- ❑ Niacin or omega-3 fatty acid

OR

- ❑ Atorvastatin, simvastatin, pravastatin, rosuvastatin

OR

- ❑ Other therapy of **(please specify)**:_____

Initiation of Treatment (submit all labs)	**Reauthorization** (submit all labs)
HbA1c%	HbA1c%
Fasting glucose mg/dL	Fasting glucose mg/dL
Triglyceride mg/dL	Triglyceride mg/dL
Patient weight kg	Patient weight kg
	Has the patient experienced clinical improvement or metabolic stabilization while using this medication? **(submit chart notes to verify response)** ❑ Yes ❑ No

*****If approved, response to initial treatment will be assessed after 4 months, then quarterly reassessment will be required for continued approval*****

Medication being provided by a Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.

Patient Name: _____

Member Optima #: _____ Date of Birth: _____

Prescriber Name: _____

Prescriber Signature: _____ Date: _____

Office Contact Name: _____

Phone Number: _____ Fax Number: _____

DEA OR NPI #: _____

***REVISED/UPDATED:** ~~8/26/2017;~~ **8/27/2018**;