

OPTIMA HEALTH COMMUNITY CARE

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 1-800-319-5003. 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. If incomplete, 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. Lab results and chart notes **MUST** be attached.

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

- 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

- Fenofibrate or fenofibrate derivative

OR

- Niacin or omega-3 fatty acid

OR

- Atorvastatin, simvastatin, pravastatin, rosuvastatin

OR

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

(continued on next page)

<u>Initiation of Treatment</u> <i>(submit all labs)</i>		<u>Reauthorization</u> <i>(submit all labs)</i>	
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? <i>(submit chart notes to verify response)</i> <input type="checkbox"/> Yes <input type="checkbox"/> 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: <input type="checkbox"/> 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