OPTIMA HEALTH PLAN

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. 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)

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 #: _____

***Approved by Pharmacy and Therapeutics Committee**: 4/16/2015
REVISED/UPDATED: ~~5/27/2015~~; ~~12/28/2015~~; ~~9/22/2016~~; 12/21/2016; **8/4/2017**