Please note: All information below is required to process this request.
Mon-Fri: 6am to 6pm Eastern / Sat: 6am to 6pm Eastern

Myalept® Prior Authorization Request Form (Page 1 of 2)

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:	Specialty:	
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Acquired generalized lipodystrophy
❑ Congenital generalized lipodystrophy
❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if the patient has a leptin deficiency as defined by the following:
- ❑ Less than 4.0 ng/mL fasting leptin for females
- ❑ Less than 3.0 ng/mL fasting leptin for males

A copy of fasting laboratory leptin assay must be provided

Does the patient have a concurrent condition of diabetes mellitus or insulin resistance? ❑ **Yes** ❑ **No**

Select if the patient has failed a 30 day trial of the following:
- ❑ High-dose insulin or insulin pump
- ❑ Metformin

Chart notes must be provided

Does the patient have a concurrent condition of hypertriglyceridemia? ❑ **Yes** ❑ **No**

Has the patient failed a 30 day trial of a low-fat diet and/or dietary restrictions? ❑ **Yes** ❑ **No**
Chart notes must be provided

Select if the patient has failed a 30 day trial of the following:
- ❑ Atorvastatin, simvastatin, pravastatin, rosuvastatin
- ❑ Fenofibrate or fenofibrate derivative
- ❑ Niacin or omega-3 fatty acid

Chart notes must be provided

Document the following laboratory values:

Hemoglobin A1c (HbA1c): _____%
Fasting glucose: _____mg/dL
Triglycerides: _____mg/dL
Patient's weight: _____ kg

Laboratory values must be provided

Reauthorization:
If this is a reauthorization request, also answer the following question:

Has the patient experienced clinical improvement or metabolic stabilization while using Myalept? ❑ **Yes** ❑ **No**
Chart notes must be provided

Myalept® Prior Authorization Request Form (Page 2 of 2)

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Medication being provided by: (Please check applicable box below)

❑ PropriumRx ❑ Specialty Pharmacy (specify name): _____

****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.

Prescriber Signature: _____ **Date:** _____

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

_____

_____

Please note: This request may be denied unless all required information is received.
For urgent or expedited requests please call 1-800-711-4555.
This form may be used for non-urgent requests and faxed to 1-800-527-0531.