PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Myalept (metreleptin)

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for?

☐ Leptin Deficiency ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Specify the prescriber's specialty.

☐ Endocrinology

☐ Other (please specify)

Q4. Which type of request is this?

☐ Initial ☐ Continuation

Q5. Please provide most recent chart note, labs, and any additional documentation that may be beneficial to pharmacist and medical director during the prior authorization case review.

Q6. What is the patient's weight?

Scott&White HEALTH PLAN
PART OF BAYLOR SCOTT & WHITE HEALTH

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Q7. Does the patient have congenital or acquired generalized lipodystrophy?

☐ Yes ☐ No

Q8. Does the patient have one of the following additional diagnoses?

☐ Diabetes mellitus ☐ Hypertriglyceridemia ☐ None of the above

Q9. Does the patient have failure of maximum tolerable doses of at least TWO conventional therapies for each additional diagnosis listed above in question 8? (Please list)

☐ Yes ☐ No

Q10. Has the patient failed lifestyle modification (diet and exercise) and will continue lifestyle modification while on Myalept?

☐ Yes ☐ No

Q11. Does the patient have any of the following?

- ☐ Hypersensitivity (e.g. anaphylaxis, urticarial, generalized rash) to Myalept or any component of the formulation
- ☐ General obesity not associated with congenital leptin deficiency
- ☐ Liver disease including nonalcoholic steatohepatitis (NASH)
- ☐ History of lymphoma
- ☐ Presence of anti-metreleptin antibodies
- ☐ HIV-related lipodystrophy
- ☐ Metabolic diseases without concurrent evidence of congenital or acquired lipodystrophy
- ☐ Complications from partial lipodystrophy (Barraquer-Simons' syndrome)

Q12. For continuation, does the patient have documented sustained reduction (from baseline) in HbA1c or triglycerides? (please provide clinical documentation)

- ☐ HbA1c
- ☐ Triglycerides
- ☐ None of the above or other (please specify)
- ☐ Not applicable (initial request)

Q13. Additional Comments

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Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.