



Please complete ALL information below and fax your request to 1-888-671-5285

### Myalept® Prior Authorization Request Form

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#### 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:
<input type="checkbox"/> Check if generic substitution is acceptable		Directions for Use:	
<input type="checkbox"/> Check if request is for continuation of therapy			

#### Clinical Information (required)

**Select the diagnosis below:**

Congenital or acquired generalized lipodystrophy (excluding other forms of lipodystrophy)

Other diagnosis: \_\_\_\_\_ ICD-10 Code(s): \_\_\_\_\_

**Clinical Information:**

Is Myalept prescribed as an adjunct to diet as replacement therapy?  Yes  No

Is the patient refractory to current standards of care for lipid and diabetic management?  Yes  No

Is Myalept prescribed by or in consultation with an endocrinologist?  Yes  No

Select if there is documentation demonstrating that the patient has the following metabolic abnormalities:

Insulin resistance (defined as requiring more than 200 units per day)

Hypertriglyceridemia

Diabetes

**Continuation:**

Does the patient have documented positive clinical response to metreleptin (Myalept) therapy (e.g. sustained reduction in Hemoglobin A1c or triglycerides from baseline)?  Yes  No

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

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Please note: This request may be denied unless all required information is received.

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