FUTURE SCRIPTS

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

Myalept® Prior Authorization Request Form

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 **generic substitution** is acceptable	Directions for Use:	
❑ 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?

_____

_____

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