



Myalept

HMSA - Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-237-5512.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-808-254-4414**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

Patient's Name: _____ **Date:** _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Patient's Phone Number: _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Additional Demographic Information:

Patient Weight: _____ kg
Patient Height: _____ ft _____ inches

Criteria Questions:

- Indicate where the drug is being dispensed:**
 - Office Outpatient Hospital Ambulatory Surgical Inpatient Hospital
 - Off Campus Outpatient Hospital Urgent Care Emergency Room Birthing Center
 - Military Facility Skilled Nursing Facility Nursing Facility Hospice
 - Inpatient Psychiatric Psychiatric Residential Treatment End Stage Renal Facility
 - Psychiatric Facility Pharmacy Other
- Indicate where the drug is being administered:**
 - Ambulatory surgical Home Inpatient hospital Office
 - Outpatient Hospital Pharmacy
- What is the ICD-10 code? _____
- What is the diagnosis?
 - Generalized lipodystrophy
 - Partial lipodystrophy
 - HIV-related lipodystrophy
 - Generalized obesity not associated with generalized lipodystrophy
 - Other _____
- Was Myalept previously authorized by HMSA/CVS for this member?
 - Yes No Unknown *If No or Unknown skip to diagnosis section*

Send completed form to: CVS Caremark Specialty Programs. Fax: 1-866-237-5512

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Myalept HMSA – 11/2022.

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6. Has the patient experienced an improvement from baseline in metabolic control (e.g., improved glycemic control, decrease in triglycerides, decrease in hepatic enzyme levels)? Yes No *No further questions*

Complete the following section based on the patient's diagnosis, if applicable.

Section A: Generalized Lipodystrophy

7. Which type of generalized lipodystrophy does the patient have?
 Congenital generalized lipodystrophy (i.e., Berardinelli-Seip syndrome)
 Acquired generalized lipodystrophy (i.e., Lawrence syndrome)
 Other _____
8. Does the patient have leptin deficiency confirmed by laboratory testing (i.e., less than 12ng/ml)? **ACTION REQUIRED: If 'Yes', attach lab report with pretreatment leptin level.** Yes No
9. Does the patient have at least one complication of lipodystrophy (e.g., diabetes mellitus, hypertriglyceridemia, increased fasting insulin level)? Yes No

Section B: Partial Lipodystrophy

10. Does the patient have leptin deficiency confirmed by laboratory testing (i.e., less than 12ng/ml)? **ACTION REQUIRED: If 'Yes', attach lab report with pretreatment leptin level.** Yes No
11. Does the patient have at least one complication of lipodystrophy (e.g., diabetes mellitus, hypertriglyceridemia, increased fasting insulin level)? Yes No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X _____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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