

# Priority Health Medicare prior authorization form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to:  Medicare Part B  Medicare Part D  
 This request is:  Expedited request  Standard request

Your request will be expedited if you haven't gotten the prescription and Priority Health Medicare determines, or your prescriber tells us, that your life or health may be at risk by waiting.

## Myalept<sup>®</sup> (metreleptin)

### Member

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
 ID #: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: \_\_\_\_\_  
 Primary Care Physician: \_\_\_\_\_  
 Requesting Provider: \_\_\_\_\_ Prov. Phone: \_\_\_\_\_ Prov. Fax: \_\_\_\_\_  
 Provider Address: \_\_\_\_\_  
 Provider NPI: \_\_\_\_\_ Contact Name: \_\_\_\_\_  
 Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Product Information

New request  Continuation request

Drug product:  Myalept 5 mg/5 mL vial  
 Start date (or date of next dose): \_\_\_\_\_  
 Date of last dose (if applicable): \_\_\_\_\_  
 Dosing frequency: \_\_\_\_\_

### Prior authorization criteria

The following requirements need to be met before this drug is covered by Priority Health Medicare. These requirements have been approved by the Centers for Medicare and Medicaid Services (CMS), but you may ask us for an exception if you believe one or more of these requirements should be waived.

1. Must have acquired or congenital generalized lipodystrophy resulting in leptin deficiency complications
  - Laboratory leptin assay results confirming leptin deficiency must be provided
2. Must have one of the following metabolic abnormalities:
  - Diabetes mellitus
  - Triglyceride level more than 200 mg/dL
3. Must not have:
  - HIV
  - Infectious liver disease
  - Acquired lipodystrophy with hematologic abnormalities

**Yearly prior authorization is required.**

### Medically accepted indication

This drug is only covered under Medicare Part D when it is used for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- — or — supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.)

---

**New request**  
**Priority Health Precertification Documentation**

**A. Does the patient have laboratory confirmed leptin deficiency?**

- Yes (Fax a copy of the laboratory assay to Priority Health.)
- No
- Other – the patient’s condition is: \_\_\_\_\_

**B. What condition is this drug being requested for?**

- Acquired generalized lipodystrophy
- Congenital generalized lipodystrophy
- Other – the patient’s condition is: \_\_\_\_\_

**C. Which of the following conditions, if any, does the patient have?**

- Diabetes mellitus
- Triglyceride level more than 200 mg/dL [The patient’s TG level was \_\_\_\_\_ mg/dL on \_\_\_\_\_ (date).]
- None of the above

**D. Which of the of following conditions, if any, does the patient have?**

- HIV
- Infectious liver disease
- Acquired lipodystrophy with hematologic abnormalities  None of the above

---

**Priority Health Medicare exception request**

**Do you believe one or more of the prior authorization requirements should be waived?**  Yes  No  
If yes, you must provide a statement explaining the medical reason why the exception should be approved.

**Would Myalept likely be the most effective option for this patient?**

- No
  - Yes, because: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

**If the patient is currently using Myalept, would changing the patient’s current regimen likely result in adverse effects for the patient?**

- No
  - Yes, because: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_