

MYALEPT

PRIOR AUTHORIZATION

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient’s life, health or ability to regain maximum function

Today’s Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today’s Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient’s Diagnosis: <input type="checkbox"/> Congenital generalized lipodystrophy (CGL) <input type="checkbox"/> Acquired generalized lipodystrophy (AGL) <input type="checkbox"/> Other (ICD code plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. What is the patient’s weight (kg)? _____ 2. Is the patient currently treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 3. Does the patient have any FDA labeled contraindications to the requested agent? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindication(s): _____ _____ 4. Is the prescriber a specialist in the area of the patient’s diagnosis (e.g., endocrinologist), or has the prescriber consulted with a specialist in the area of the patient’s diagnosis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Has the patient had an inadequate response to lifestyle modification (i.e., diet modification and exercise)?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, will the patient continue lifestyle modifications (i.e., diet and exercise) with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Please list all reasons for selecting the requested agent, strength, dosing schedule, and quantity over alternatives (e.g., contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). Please note, documentation may be required: _____ _____ _____ _____	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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For congenital generalized lipodystrophy (CGL) and acquired generalized lipodystrophy (AGL) requests:

7. Does the patient have a leptin deficiency confirmed by laboratory testing (i.e., less than 12 ng/mL) prior to initiating the requested agent? Yes No
8. Does the patient have at least ONE of the following complications related to lipodystrophy? (Select one.)
- Diabetes mellitus
 - Hyperinsulinemia (i.e., greater than or equal to 30 microU/mL)
 - Hypertriglyceridemia (i.e., greater than or equal to 200 mg/dL)
 - None of the above
9. Has the patient's baseline HbA1c, triglycerides, and fasting insulin levels been measured prior to initiating the requested agent? Yes No
10. Has the patient tried and had an inadequate response to the maximum tolerable dose of a conventional agent for complications related to lipodystrophy? Yes No
11. Does the patient have ANY of the following limitations of use for the requested agent? (Select one.)
- Partial lipodystrophy
 - Liver disease (including non-alcoholic steatohepatitis [NASH] or metabolic associated steatohepatitis [MASH])
 - HIV-related lipodystrophy
 - Metabolic disease (e.g., diabetes mellitus, hypertriglyceridemia) without evidence of generalized lipodystrophy)
 - None of the above

For renewal requests:

12. Has the patient had clinical benefit with the requested agent? Yes No
13. Will the patient continue lifestyle modifications (i.e., diet and exercise) with the requested agent? Yes No

Please fax or mail this form to:

Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone:

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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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