AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

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Drug Requested: Myalept® (metreleptin)

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

INITIATION AND CONTINUATION OF TREATMENT – All boxes below must be checked to qualify.

- ❑ Member has a leptin deficiency as defined as **(a copy of fasting laboratory leptin assay results is required for approval):**
  - ❑ <4.0 ng/mL fasting leptin for females
  - ❑ <3.0 ng/mL fasting leptin for males
- ❑ Member has a diagnosis of **(choose indication):**
  - ❑ Acquired generalized lipodystrophy
  - ❑ Congenital generalized lipodystrophy

(Continued on next page)

- ❑ Member has a concurrent condition of:
  - ❑ Diabetes mellitus or insulin resistance and failed 30-day trial of (submit chart notes):
    - ❑ Metformin, total daily dose of: _____

AND

    - ❑ High-dose insulin or insulin pump
  - ❑ Hypertriglyceridemia and failed 30-day trial of (submit chart notes):
    - ❑ Low-fat diet and/or dietary restrictions

AND

    - ❑ Fenofibrate or fenofibrate derivative

OR

    - ❑ Niacin or omega-3 fatty acid

OR

    - ❑ Atorvastatin, simvastatin, pravastatin, rosuvastatin

OR

    - ❑ Other therapy of (**please specify**): _____

INITIATION OF TREATMENT (submit all labs)	**REAUTHORIZATION (submit all labs)**
HbA1c%	HbA1c%
Fasting glucose _____ mg/dL	Fasting glucose _____ mg/dL
Triglyceride _____ mg/dL	Triglyceride _____ mg/dL
Patient weight _____ kg	Patient weight _____ kg
	Has member experienced clinical improvement or metabolic stabilization while using this medication? **(submit chart notes to verify response)** ❑ Yes ❑ No

If approved, response to initial treatment will be **assessed after 4 months**, then **quarterly reassessment** will be required for continued approval.

Medication being provided by Specialty Pharmacy - PropriumRx

Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.*

Previous therapies will be verified through pharmacy paid claims or submitted chart notes.