Myalept

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 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** 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.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

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

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

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

Required Demographic Information:

Patient Weight: _____*kg*

*Patient Height:*_____*cm*

Please indicate the place of service for the requested drug:
❑ *Ambulatory Surgical* ❑ *Home* ❑ *Inpatient Hospital* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

CVS Caremark Specialty Pharmacy ● 2211 Sanders Road NBT-6 ● Northbrook, IL 60062
Phone: 1-888-877-0518 ● Fax: 1-855-330-1720 ● www.caremark.com

Clinical Criteria Questions:

1. What is the diagnosis?
   - ❑ Generalized lipodystrophy
   - ❑ Partial lipodystrophy
   - ❑ HIV-related lipodystrophy
   - ❑ Generalized obesity not associated with generalized lipodystrophy
   - ❑ Other _____
2. What is the ICD-10 code? _____
3. Is this a request for initial therapy or continuation of therapy with Myalept?
   If Initial, skip to #5 ❑ Initial ❑ Continuation
4. 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*
5. *If the diagnosis is generalized lipodystrophy,* 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 _____
6. 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
7. 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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