

Member Name: {{MEMFIRST}} {{MEMLAST}} DOB: {{MEMBERDOB}} PA Number: {{PANUMBER}}



[[PANUMCODE]]

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 1-866-249-6155.** If you have questions regarding the prior authorization, please contact CVS Caremark at 1-866-814-5506. 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.

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Patient's Name: {{MEMFIRST}} {{MEMLAST}} **Date:** {{TODAY}}
Patient's ID {{MEMBERID}} **Patient's Date of Birth:** {{MEMBERDOB}}
Physician's Name: {{PHYFIRST}} {{PHYLAST}}
Specialty: _____, **NPI#:** _____
Physician Office Telephone: {{PHYSICIANPHONE}} **Physician Office Fax:** {{PHYSICIANFAX}}
Request Initiated For: {{DRUGNAME}}

- What is the diagnosis?
 Congenital generalized lipodystrophy (i.e., Berardinelli-Seip syndrome)
 Acquired generalized lipodystrophy (i.e., Lawrence syndrome)
 HIV-related lipodystrophy
 Partial lipodystrophy
 Generalized obesity not associated with generalized lipodystrophy
 Other _____
- What is the ICD-10 code? _____
If diagnosis is HIV-related lipodystrophy or Generalized obesity not associated with generalized lipodystrophy, no further questions.
- Is the patient currently receiving treatment with the requested medication? Yes No *If No, skip to #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.*
- 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
- 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)

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

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 SGM - 9/2023.

CVS Caremark Prior Authorization • 1300 E. Campbell Road • Richardson, TX 75081

Phone: 1-866-814-5506 • Fax: 1-866-249-6155 • www.caremark.com