



## 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.

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**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       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**

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 1674-A - 08/2023.

**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:**

What is the ICD-10 code? \_\_\_\_\_

1. What is the diagnosis?

- Congenital generalized lipodystrophy (i.e., Berardinelli-Seip syndrome), *Continue to 2*
- Acquired generalized lipodystrophy (i.e., Lawrence syndrome), *Continue to 2*
- Partial lipodystrophy, *Continue to 2*
- HIV-related lipodystrophy, *Continue to 2*
- Generalized obesity not associated with generalized lipodystrophy, *Continue to 2*
- Other, please specify. \_\_\_\_\_, *Continue to 2*

2. Is the patient currently receiving treatment with the requested medication

- Yes, *Continue to 3*
- No, *Continue to 4*

3. 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 Further Questions*
- No, *No Further Questions*

4. Does the patient have leptin deficiency confirmed by laboratory testing (i.e., less than 12 ng/ml)? **ACTION REQUIRED:** If Yes, attach lab report with pretreatment leptin level. **ACTION REQUIRED:** Submit supporting documentation

- Yes, *Continue to 5*
- No, *Continue to 5*

5. Does the patient have at least one complication of lipodystrophy (e.g., diabetes mellitus, hypertriglyceridemia, increased fasting insulin level)?

- Yes, *No Further Questions*
- No, *No Further Questions*

***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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