

Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
MYALEPT (Metreleptin) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 4 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **MYALEPT (Metreleptin).** <u>Please complete all sections, incomplete forms will delay processing.</u> <u>Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104</u>. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: http://www.providers.kaiserpermanente.org/mas/formulary.html

	1 – Patient Information	
Patient Name:	Kaiser Medical ID#:	Date of Birth:
	2 – Prescriber Information	
Is the prescriber an Endocrinologist?	No □ Yes	
If consulted with a specialist, specialist r	name and specialty:	
Prescriber Name:	Specialty:	NPI:
Prescriber Address:		
	Prescriber Fax #:	
3 – Pharmacy Information		
Pharmacy Name:	Pharmacy NPI:	
Pharmacy Phone #	Pharmacy Fax #:	
	4 – Drug Therapy Requested	
Drug 1: Name/Strength/Formulation:		
Drug 2: Name/Strongth/Formulation		
315		

5- Diagnosis/Clinical Criteria

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1.	Is this request for initial or continuing therapy? □ Initial therapy □ Continuing therapy, State date:
2.	□ Initial therapy □ Continuing therapy, State date: Indicate the Member's diagnosis for the requested medication:
3.	Does the member have a diagnosis for the requested medication. Does the member have a diagnosis of congenial or acquired generalized lipodystrophy associated with leptin deficiency (less than 12.0 ng/mL in females and less than 8.0 mg/mL in males)? AND □ No □ Yes
4.	Is being used as an adjunct to diet modification? AND □ No □ Yes
5.	 Has documentation demonstrates that the member has at least ONE of the following: a. Diabetes mellitus or insulin resistance with persistent hyperglycemia (HgbA1C >7) despite BOTH of the following: 1. Dietary intervention 2. Optimized insulin therapy at maximum tolerated doses □ No □ Yes
For Coi	 b. Persistent hypertriglyceridemia (TG >200) despite <u>BOTH</u> of the following: Dietary intervention Optimized therapy with at least two triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses No □ Yes ntinuation of Therapy, Please Respond to Additional Questions Below:
	Member has documentation of positive clinical response and/or stabilization of laboratory parameters provided in initial authorization (i.e. fasting triglyceride concentrations, and/or HbA1C), AND □ No □ Yes
2.	Is being used as an adjunct to diet modification, AND □ No □ Yes
3.	Continues to be prescribed by an Endocrinologist? □ No □ Yes
	6 – Prescriber Sign-Off
Provide	onal Information – Please submit chart notes/medical records for the patient that are applicable to this request. e any additional supporting information that should be taken into consideration:
	ify that the information provided is accurate. Supporting documentation is available for State audits. Date:
	ote: This document contains confidential information, including protected health information, intended for a specific individual and purpose. The information is and legally protected by law, including HIPAA. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution or taking of

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