



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)**. Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. 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 name and specialty: \_\_\_\_\_

Prescriber Name: \_\_\_\_\_ Specialty: \_\_\_\_\_ NPI: \_\_\_\_\_

Prescriber Address: \_\_\_\_\_

Prescriber Phone #: \_\_\_\_\_ Prescriber Fax #: \_\_\_\_\_

**3 – Pharmacy Information**

Pharmacy Name: \_\_\_\_\_ Pharmacy NPI: \_\_\_\_\_

Pharmacy Phone # \_\_\_\_\_ Pharmacy Fax #: \_\_\_\_\_

**4 – Drug Therapy Requested**

Drug 1: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

Drug 2: Name/Strength/Formulation: \_\_\_\_\_

Sig: \_\_\_\_\_

### 5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?  
 Initial therapy                       Continuing therapy, State date: \_\_\_\_\_
2. Indicate the Member's diagnosis for the requested medication: \_\_\_\_\_
3. 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
  - b. Persistent hypertriglyceridemia (TG >200) despite BOTH of the following:
    1. Dietary intervention
    2. Optimized therapy with at least two triglyceride-lowering agents from different classes (e.g., fibrates, statins) at maximum tolerated doses No  Yes

#### For Continuation of Therapy, Please Respond to Additional Questions Below:

1. 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

**Additional Information – Please submit chart notes/medical records for the patient that are applicable to this request. Provide any additional supporting information that should be taken into consideration:**

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**I certify that the information provided is accurate. Supporting documentation is available for State audits.**

**Prescriber Signature:**

**Date:**

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