Health Partners Plans

HEALTH PARTNERS MEDICARE
PRIOR AUTHORIZATION REQUEST FORM

Myalept - Medicare

Phone: 215-991-4300 **Fax back to: 866-371-3239**

Health Partners Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: □ Medicare	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that applying the 72 hour standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:
Strength:
Directions / SIG:

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Has the patient been previously approved for Myalept therapy?

☐ Yes ☐ No

Q2. Are the following updated labs attached: A) Hemoglobin A1C, B) Glucose, C) Triglycerides?

☐ Yes ☐ No

Q3. Does the patient have any of the following conditions: A) General obesity not associated with congenital leptin deficiency, B) HIV-related lipodystrophy, C) Metabolic disease, including diabetes mellitus and hypertriglyceridemia, without concurrent evidence of congenital or acquired generalized lipodystrophy?

☐ Yes ☐ No

Q4. Is Myalept being prescribed by or in consultation with an appropriate specialist or endocrinologist?

☐ Yes ☐ No

Q5. Does the patient have the diagnosis of congenital or acquired generalized lipodystrophy? Please attach documentation.

☐ Yes ☐ No

Q6. Are the following baseline labs attached: A) Hemoglobin A1C, B) Glucose, C) Triglycerides?

☐ Yes ☐ No

Q7. Additional Information:

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Patient Name:	**Prescriber Name:**

Q8. Requested Duration:

☐ 12 months

Prescriber Signature

Date

2021 Medicare Prior Authorization Request