Jefferson Health Plans

2024 MEDICARE PRIOR AUTHORIZATION REQUEST FORM

Myalept - Medicare

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

Jefferson Health 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 the drug?

☐ Yes ☐ No

Q2. Has the patient benefited from treatment with the drug?
Please attach labs (hemoglobin A1c, fasting plasma glucose, and/or triglycerides) which show a decrease since starting treatment.

☐ 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 the drug being prescribed by or in consultation with an endocrinologist?

☐ Yes ☐ No

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

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q6. Are the following baseline labs attached? A) Hemoglobin A1c, B) Fasting plasma glucose, C) Triglycerides.

☐ Yes ☐ No

Q7. Requested Duration:

☐ 12 Months ☐ Other

Q8. Additional Information:

_____ _____

Prescriber Signature Date

2024 Medicare Prior Authorization Request