Myalept® (metreleptin) Injectable Medication Precertification Request

(All fields must be completed and legible for Precertification Review)

Aetna Precertification Notification
Phone: 1-866-752-7021
FAX: 1-888-267-3277

For Medicare Advantage Part B:
Please Use Medicare Request Form.

Please indicate: ☐ Start of treatment: Start date ____/____/____
☐ Continuation of therapy: Date of last treatment ____/____/____

Precertification Requested By: ______________________ Phone: ____________ Fax: ____________

A. PATIENT INFORMATION

First Name:		Last Name:	DOB:	
Address:		City:	State:	ZIP:
Home Phone:	Work Phone:	Cell Phone:	E-mail:	
Patient Current Weight: ______ lbs or ______ kgs Patient Height: _____ inches or ______ cms			Allergies:	

B. INSURANCE INFORMATION

Aetna Member ID #: ______________________ **Group #**: ______________________ **Insured**:	Does patient have other coverage? ☐ Yes ☐ No If yes, provide ID#: ____________ Carrier Name: ______________ Insured:
Medicare: ☐ Yes ☐ No If yes, provide ID #:	**Medicaid:** ☐ Yes ☐ No If yes, provide ID #:

C. PRESCRIBER INFORMATION

First Name:		Last Name:		*(Check One)*: ☐ M.D. ☐ D.O. ☐ N.P. ☐ P.A.	
Address:		City:		State:	ZIP:
Phone:	Fax:	St Lic #:	NPI #:	DEA #:	UPIN:
Provider E-mail:		Office Contact Name:		Phone:	
Specialty *(Check one)*: ☐ **Endocrinologist** ☐ **Other**:					

D. DISPENSING PROVIDER/ADMINISTRATION INFORMATION

Place of Administration:
☐ Self-administered ☐ Physician's Office
☐ Outpatient Infusion Center Phone: ______________
Center Name: ______________
☐ Home Infusion Center Phone: ______________
Agency Name: ______________
☐ Administration code(s) (CPT): ______________
Address: ______________

Dispensing Provider/Pharmacy: ***(Patient selected choice)***
☐ Physician's Office ☐ Retail Pharmacy
☐ Specialty Pharmacy ☐ Other: ______________
Name: ______________
Address: ______________
Phone: ______________ Fax: ______________
TIN: ______________ PIN: ______________

E. PRODUCT INFORMATION

Request is for Myalept (metreleptin): Dose: ______________ **Frequency:** ______________

F. DIAGNOSIS INFORMATION - Please indicate primary ICD code and specify any other where applicable.

Primary ICD Code: ______________ ☐ Other: ______________

G. CLINICAL INFORMATION - Required clinical information must be completed in its entirety for all precertification requests.

For ALL Requests (clinical documentation required):

Please indicate the diagnosis:
- ☐ Generalized lipodystrophy
  - Please indicate which type of generalized lipodystrophy does the patient have:
    - ☐ Congenital generalized lipodystrophy (i.e., Berardinelli-Seip syndrome)
    - ☐ Acquired generalized lipodystrophy (i.e., Lawrence syndrome)
- ☐ Partial lipodystrophy
- ☐ HIV-related lipodystrophy
- ☐ Generalized obesity not associated with generalized lipodystrophy
- ☐ Other, please explain: ______________

☐ Yes ☐ No Does the patient have leptin deficiency confirmed by laboratory testing (i.e., less than 12ng/ml)?
☐ Yes ☐ No Does the patient have at least one complication of lipodystrophy (e.g., diabetes mellitus, hypertriglyceridemia, increased fasting insulin level)?

For Continuation Requests:
☐ Yes ☐ No Has the patient experienced an improvement from baseline in metabolic control (e.g., improved glycemic control, decrease in triglycerides, decrease in hepatic enzyme levels)?

H. ACKNOWLEDGEMENT

Request Completed By ***(Signature Required)*:** ______________________ **Date:** ____/____/____

Any person who knowingly files a request for authorization of coverage of a medical procedure or service with the intent to injure, defraud or deceive any insurance company by providing materially false information or conceals material information for the purpose of misleading, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

The plan may request additional information or clarification, if needed, to evaluate requests.