aetna®

Myalept® (metreleptin) Injectable Medication Precertification Request

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

Aetna Precertification Notification
503 Sunport Lane, Orlando, FL 32809
Phone: 1-866-503-0857
FAX: 1-888-267-3277

For Medicare Advantage Part B:
FAX: 1-844-268-7263

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 #: _____	Does patient have other coverage? ☐ Yes ☐ No
Group #: _____	If yes, provide ID#: _____ Carrier Name: _____
Insured:	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 ☐ Mail Order
☐ Other: _____
Name: _____
Address: _____
Phone: _____ Fax: _____
TIN: _____ PIN: _____

E. PRODUCT INFORMATION

Request is for Myalept: Dose: _____mg **Frequency:** _____

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

Primary ICD Code: ☐ _____ ☐ Other: _____ * Please attach rationale

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

For ALL Requests:

☐ Yes ☐ No Does the patient have a documented diagnosis of leptin deficiency?
☐ Yes ☐ No Is there clinical evidence of complications from leptin deficiency?
→ Please indicate the serum leptin level and date obtained: Level: _____ ng/ml Date drawn: ____/____/____
☐ Yes ☐ No Does the patient have a documented diagnosis of congenital generalized lipodystrophy or acquired generalized lipodystrophy?
☐ Yes ☐ No Will metreleptin (Myalept) be used as an adjunct to the patient's diet?
☐ Yes ☐ No Does the patient have liver disease, including nonalcoholic steatohepatitis (NASH)?

For Initiation Requests:

☐ Yes ☐ No Does the patient have clinical evidence of at least one of the following:
→ ***Check ALL that apply***:
☐ **Type 2 diabetes mellitus**
→ Please indicate the most recent HbA1c level: _____% Date: ____/____/____
→ Please indicate the most recent fasting blood glucose level: _____ mg/dl Date: ____/____/____
☐ **Hypertriglyceridemia**
→ Please indicate the most recent fasting triglyceride level: _____ mg/dL Date: ____/____/____
☐ **Hyperinsulinemia**
→ Please indicate the most recent fasting serum insulin level: _____ uU/mL Date: ____/____/____

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Patient First Name	Patient Last Name	Patient Phone	Patient DOB

G. CLINICAL INFORMATION (*continued*) - Required clinical information must be completed for ALL precertification requests.

For Continuation Requests:

☐ Yes ☐ No Has the patient's condition stabilized or improved while on Myalept?

→ Which of the concurrent diagnoses have improved or stabilized while on Myalept? ***Check ALL that apply***:

☐ **Type 2 diabetes mellitus**

→ Please indicate the value of the baseline HbA1c level: _____%

What is the patient's most recent HbA1c? HbA1c _____% Date: _____/_____/_____

Please indicate the value of the baseline fasting blood glucose level: _____ mg/dl

Please indicate the value of the most recent fasting blood glucose level: _____ mg/dl Date: _____/_____/_____

☐ **Hypertriglyceridemia**

→ Please indicate the value of the baseline fasting triglyceride level : _____ mg/dL

Please indicate the value of the most recent fasting triglyceride level : _____ mg/dL Date: _____/_____/_____

☐ **Hyperinsulinemia**

→ Please indicate the value of the baseline fasting serum insulin level: _____ uU/mL

Please indicate the value of the most recent fasting serum insulin level: _____ uU/mL Date: _____/_____/_____

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.