



MEDICARE ADVANTAGE PRIOR AUTHORIZATION REQUEST FORM

Myalept - Medicare

Applies to Core 5T and Premium 1T Formularies Only

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.

Member Name:	Prescriber Name:	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Line of Business: <input type="checkbox"/> Medicare Advantage	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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q2. For Renewal: 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. <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No
Q4. Is the drug being prescribed by, or in consultation with, an endocrinologist? <input type="checkbox"/> Yes <input type="checkbox"/> No

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Member Name:	Prescriber Name:
Q5. Does the patient have a diagnosis of congenital or acquired generalized lipodystrophy? Please attach documentation. <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q6. Are the following baseline labs attached: A) Hemoglobin A1c; B) Fasting plasma glucose; C) Triglycerides? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Q7. Requested Duration: <input type="checkbox"/> 12 Months <input type="checkbox"/> Other	
Q8. Additional Information:	

Prescriber Signature

Date

v2025