



Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}

To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst}
{Auth.Member.MemberNameLast}

Electronically (4-5 minutes process time)	Phone (10-15 minutes process time)	Fax (24-72 hours process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

The information contained in this message may be privileged and confidential and protected from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by replying to the message and deleting it from your computer. Thank you, CVS/Caremark.

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:**
{Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}



Myalept

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720.** If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518**. For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient Name: {Auth.Member.MemberNameFirst}

Date: {System.DateTime.Today}

{Auth.Member.MemberNameLast}

Patient's ID: {Auth.Member.MemberID}

Patient's Date of Birth:

{Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}

Specialty: _____

NPI#: {Auth.ProviderBilling.NPI}

Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

Physician Office Fax:

{Auth.OfficeContactFaxNumber}

Referring Provider Info: ☐ Same as Requesting Provider

Name: _____

NPI#: _____

Fax: _____

Phone: _____

Rendering Provider Info: ☐ Same as Referring Provider ☐ Same as Requesting Provider

Name: _____

NPI#: _____

Fax: _____

Phone: _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____ *kg*

Patient Height: _____ *cm*

Please indicate the place of service for the requested drug:

☐ Ambulatory Surgical

☐ Home

☐ Off Campus Outpatient Hospital

☐ On Campus Outpatient Hospital

☐ Office

☐ Pharmacy

Clinical Criteria Questions:

What is the ICD-10 code? _____

1. What is the diagnosis?

☐ Congenital generalized lipodystrophy (i.e., Berardinelli-Seip syndrome), *Continue to 2*

☐ Acquired generalized lipodystrophy (i.e., Lawrence syndrome), *Continue to 2*

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Myalept SGM 1674-A - 08.2023.

CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062

Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

- ☐ Partial lipodystrophy, *Continue to 2*
- ☐ HIV-related lipodystrophy, *Continue to 2*
- ☐ Generalized obesity not associated with generalized lipodystrophy, *Continue to 2*
- ☐ Other, please specify. _____, *Continue to 2*
- 2. Is the patient currently receiving treatment with the requested medication
 - ☐ Yes, *Continue to 3*
 - ☐ No, *Continue to 4*
- 3. Has the patient experienced an improvement from baseline in metabolic control (e.g., improved glycemic control, decrease in triglycerides, decrease in hepatic enzyme levels)?
 - ☐ Yes, *No Further Questions*
 - ☐ No, *No Further Questions*
- 4. Does the patient have leptin deficiency confirmed by laboratory testing (i.e., less than 12 ng/ml)? **ACTION REQUIRED:** If Yes, attach lab report with pretreatment leptin level. **ACTION REQUIRED:** Submit supporting documentation
 - ☐ Yes, *Continue to 5*
 - ☐ No, *Continue to 5*
- 5. Does the patient have at least one complication of lipodystrophy (e.g., diabetes mellitus, hypertriglyceridemia, increased fasting insulin level)?
 - ☐ Yes, *No Further Questions*
 - ☐ No, *No Further Questions*

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____

Prescriber or Authorized Signature

Date (mm/dd/yy)

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

Note: This fax may contain medical information that is privileged and confidential and is solely for the use of individuals named above. If you are not the intended recipient you hereby are advised that any dissemination, distribution, or copying of this communication is prohibited. If you have received the fax in error, please immediately notify the sender by telephone and destroy the original fax message. Myalept SGM 1674-A - 08.2023.

**CVS Caremark Specialty Pharmacy • 2211 Sanders Road NBT-6 • Northbrook, IL 60062
Phone: 1-888-877-0518 • Fax: 1-855-330-1720 • www.caremark.com**