Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Myalept – Medical Necessity Request

Complete page 1 for Initial Requests Only*

1. Does the member have a diagnosis of Congenital Generalized Lipodystrophy (CGL) or Acquired Generalized Lipodystrophy (AGL) associated with leptin deficiency?
   □ **Yes**
   □ **No** - what is the member's diagnosis? _____

2. Will the medication be used as an adjunct to diet modification? **Yes or No**

3. Is the medication being prescribed by or in consultation with a specialist in the disease (e.g. endocrinologist, cardiologist)? **Yes or No**

4. What is the member's current weight? _____lbs or _____ kg

5. What is the member's current triglycerides level prior to starting Myalept treatment?_____

6. What is the member's current hemoglobin A1C (HbA1c) level prior to starting Myalept treatment?_____

7. What is the member's current fasting glucose level prior to starting Myalept treatment?_____

Physician office's signature*_____ Print Name_____
***Form must be completed and signed by physician or licensed representative from the physician's office**

Member Name: _____ Member ID: _____ Member DOB: _____

Drug Name: _____ Strength: _____ Directions: _____

Physician Name: _____ Physician Phone #: _____ Specialty: _____

Physician Fax #: _____ Pharmacy Name: _____Pharmacy Phone: _____

Horizon NJ Health

Myalept – Medical Necessity Request

*****Complete page 2 only for Subsequent/Renewal requests*****

1. What is the member's current triglycerides level? _____
2. What is the member's current hemoglobin A1C (HbA1c) level? _____
3. What is the member's current fasting glucose level? _____
4. Is the medication being prescribed by or in consultation with a specialist in the disease (e.g. endocrinologist, cardiologist)? **Yes or No**
5. Will the medication be used as an adjunct to diet modification? **Yes or No**
6. Please let us know the member's current weight: ____ lbs or ____kg

Physician office's signature*_____ Print Name_____

***Form must be completed and signed by physician or licensed representative from the physician's office**