Prior Authorization Request Form for
Setmelanotide **(Imcivree)**

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTHCARE
7231 Parkway Drive, Suite 100, Hanover, MD 21076

USFHP Pharmacy Prior Authorization Form

FAX Completed Form and Applicable Progress Notes to: (410) 424-4037

To be completed by Requesting provider	
Drug Name:	Strength:
Dosage/Frequency (SIG):	Duration of Therapy:

Questions? Contact the Pharmacy Dept at: (888) 819-1043, option 4

Clinical Documentation must accompany form in order for a determination to be made.

Step 1 **Please complete patient and physician information** (please print):

Patient Name:		Physician Name:	
Address:		Address:	
Sponsor ID #		Phone #:	
Date of Birth:		Secure Fax #:	

Step 2 **Please complete the clinical assessment:**

1. **Has the patient received this medication under the TRICARE benefit in the last 6 months?** *Please choose "No" if the patient did not previously have a TRICARE approved PA for Imcivree.*	☐ Yes Proceed to question **2**	☐ No Proceed to question **3**
2. **Does the patient have a documented improvement (a decrease from baseline) in at least 5% of baseline body weight, or 5% of baseline BMI for patients with continued growth potential?**	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved
3. **Is the patient greater than or equal to 6 years of age?**	☐ Yes Proceed to question **4**	☐ No **STOP** Coverage not approved
4. **Does the patient have a confirmed diagnosis (via genetic testing) of POMC-, PCSK1-, or LEPR-deficiency that are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS)?** **Note: Non-FDA approved uses are NOT approved including Alstrom Syndrome, POMC-, PCSK1-, or LEPR-deficiency with POMC, PCSK1, or LEPR variants classified as benign or likely benign, other types of obesity not related to POMC, PCSK1 or LEPR deficiency, including obesity associated with other genetic syndromes and general (polygenic) obesity.**	☐ Yes Proceed to question **6**	☐ No Proceed to question **5**

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5. **Does the patient have monogenic or syndromic obesity due to Bardet-Beidl syndrome (BBS)?** **Note: Non-FDA approved uses are NOT approved including Alstrom Syndrome, POMC-, PCSK1-, or LEPR-deficiency with POMC, PCSK1, or LEPR variants classified as benign or likely benign, other types of obesity not related to POMC, PCSK1 or LEPR deficiency, including obesity associated with other genetic syndromes and general (polygenic) obesity.**	☐ Yes Proceed to question **6**	☐ No **STOP** Coverage not approved
6. **Does the patient and provider agree to evaluate weight loss after 12-16 weeks of treatment? NOTE - Imcivree should be discontinued if a patient has not lost at least 5% of baseline body weight, or 5% of baseline BMI for patients with continued growth potential.**	☐ Yes **Sign and date below**	☐ No **STOP** Coverage not approved

Step 3 **I certify the above is true to the best of my knowledge.**

Please sign and date:

______________________________ Prescriber Signature

______________ Date

[09 December 2022]

For Internal Use Only	
☐ Approved:	Duration of Approval: _____month(s)
☐ Denied:	Authorized By:
☐ Incomplete/Other:	PA#: