IOWA Health and Human Services

Request for Prior Authorization

SETMELANOTIDE (IMCIVREE)

(PLEASE PRINT – ACCURACY IS IMPORTANT)

FAX Completed Form To
1 (800) 574-2515

Provider Help Desk
1 (877) 776-1567

IA Medicaid Member ID #	Patient name	DOB
Patient address		
Provider NPI	Prescriber name	Phone
Prescriber address		Fax
Pharmacy name	Address	Phone
Prescriber must complete all information above. It must be legible, correct, and complete or form will be returned.		
Pharmacy NPI	Pharmacy fax	NDC

Prior authorization (PA) is required for setmelanotide (Imcivree). Payment will be considered for an FDA approved or compendia indicated diagnosis for the requested drug when the following conditions are met:

1. **Request adheres to all FDA approved labeling for requested drug and indication, including age, dosing, contraindications, warnings and precautions, drug interactions, and use in specific populations; and**
2. **Documentation of the patient's baseline weight (kg) and body mass index (BMI) obtained within the past 60 days is provided; and**
3. **Patient must have a diagnosis of obesity (BMI > 30kg/m^2 for adults or 95th percentile using growth chart assessments for pediatric patients (attach growth chart assessments for pediatric patients); and**
4. **Patient has a diagnosis of obesity due to one of the following:**
    a. **Proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, and**
        i. **Genetic testing demonstrates that variants in POMC, PCSK1, or LEPR genes are interpreted as pathogenic, likely pathogenic, or of uncertain significance (attach results); or**
    b. **Bardet-Biedl syndrome (BBS) as evidenced by documentation in the patient's chart notes (attach documentation); or**
    c. **Acquired hypothalamic obesity (HO) as evidenced by documentation in the patient's chart notes (attach documentation) of having or had a hypothalamic tumor, hypothalamic lesion, or hypothalamic damage or injury; and**
5. **Is prescribed by or in consultation with an endocrinologist, a geneticist, or an expert in rare genetic disorders of obesity.**

If criteria for coverage are met, initial requests will be approved for 1 year. Additional approvals will be considered under the following conditions:

1. **Patient's current weight (kg) and BMI document a decrease of at least 5% of baseline body weight (or at least 5% baseline BMI for patients with continued growth potential, attach growth chart assessment) since initiating treatment.**

Non-Preferred

☐ Imcivree

Strength	Dosage Instructions	Quantity	Days Supply

Diagnosis: _____

Iowa Department of Human Services

Request for Prior Authorization-*Continued*
SETMELANOTIDE (IMCIVREE)

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Patient's weight (kg): _____ **Patient's BMI:** _____ **Date obtained:** _____

Does patient have a diagnosis of obesity?

☐ No ☐ Yes (provide growth chart assessments for pediatric patients)

Patient has a diagnosis of obesity due to one of the following:

- POMC, PCSK1, or LEPR deficiency (attach results of genetic testing demonstrating variants in POMC, PCSK1, or LEPR genes that are interpreted as pathogenic, likely pathogenic, or of uncertain significance)
- BBS (attach chart notes)
- Acquired HO (attach chart notes documenting hypothalamic tumor, hypothalamic lesion, or hypothalamic damage or injury)

Is prescriber an endocrinologist, geneticist, or an expert in rare genetic disorders of obesity?

- Yes, document specialty: _____
- No, note consultation with specialist: Consultation Date: _____

  Physician Name, Specialty & Phone: _____

<u>Renewal Requests</u>

Patient's weight (kg): _____ **Patient's BMI:** _____ **Date obtained:** _____

Has the patient experienced a decrease of at least 5% of baseline body weight (or at least 5% of baseline BMI for patients with continued growth potential, attach growth chart assessment) since initiating treatment?

☐ No ☐ Yes

Attach lab results and other documentation as necessary.

Prescriber signature (Must match prescriber listed above.)	Date of submission

IMPORTANT NOTE: *In evaluating requests for prior authorization, the consultant will consider the treatment from the standpoint of medical necessity only. If approval of this request is granted, this does not indicate that the member continues to be eligible for Medicaid. It is the responsibility of the provider who initiates the request for prior authorization to establish by inspection of the member's Medicaid eligibility card and, if necessary, by contact with the county Department of Health and Human Services, that the member continues to be eligible for Medicaid.*