Imcivree Prior Authorization Form
Maryland Medicaid Pharmacy Program
Fax: 410 333 5398 Phone: 800 932 3918
Incomplete forms will not be reviewed

Date: _____

Patient's Information

Name: _____ DOB: _____

Maryland Medicaid Number: _____ Sex: ❑ Male ❑ Female

Prescriber's Information:

Name: _____ NPI#: _____

Phone#: _____ Fax#: _____

Contact Person for this Request:

Name: _____ Phone#: _____

Requested Drug Information

❑ Imcivree ® (setmelanotide)

❑ New Request ❑ Refill

Strength: _____ Quantity: _____

Directions: _____

Clinical Information:

Clinical documentation supporting the following must be submitted:

1. Body mass index (BMI):

   ❑ BMI > 30 kg/m2 for adults

   ❑ BMI > 95th percentile on pediatric growth chart for pediatric patients for obesity due to POMC, PCSK1 or LEPR deficiencies

   ❑ BMI >97th percentile using growth chart assessments for pediatric patients for obesity due to BBS

2. Age restrictions

   ❑ Imcivree only for patients 2 years or older

3. Initial Request Requirements:

   ❑ Provider attestation that all FDA precautions/warnings, contraindications to treatment, and any Black Box Warnings have been considered.

   ❑ Prescribed by or in consultation with an endocrinologist or geneticist

   ❑ Member has proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, as confirmed by a genetic test AND

   ❑ Member's genetic variants are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS) OR

   ❑ Member has Bardet-Biedl syndrome (BBS)

   ❑ Member has eGFR greater than 15mL/min/1.73 m2

4. The written documentation must include:
   ❑ Provider attestation that these medications will not be used concurrently with another weight loss medication which include prescription medications, over-the-counter drugs, and herbal preparations.
   ❑ Documentation that a medical work up has excluded organic causes of obesity (i.e. Hypothyroidism).

5. Length of Authorization:
   Weight management medications will be renewed depending on the specific medication. Renewal requests will NOT be authorized if the member's BMI is < or =24. Please refer to Imcivree clinical criteria for further details at: https://health.maryland.gov/mmcp/pap/pages/Clinical-Criteria.aspx

Medication	Initial Approval	Renewal Approval
Imcivree	4 Months	6 Months

6. Assessment: _____

7. Other Diagnoses/Risk Factors: _____

8. Baseline BMI: _____ Baseline Weight: _____ Height: _____

9. Document details of most recent weight loss treatment plans to include diet and exercise plans. Submit copy of plan. Additional Comments: _____

I certify that the benefits of the treatment for this patient outweigh the risks and verify that the information provided on this form is true and accurate to the best of my knowledge. Supporting medical documentation is kept on file in the patient's medical record.

I certify the patient is not enrolled in any study involving the requested drug.

MDH and prescriber acknowledge and agree that this request may be executed by electronic signature, which shall be considered as an original signature.

Prescriber's Signature: _____ Date: _____