Kaiser Permanente Health Plan of Mid-Atlantic States, Inc.
Imcivree (setmelanotide) Prior Authorization (PA)
Pharmacy Benefits Prior Authorization Help Desk
Length of Authorizations: Initial- 4 months; Continuation- 12 months

Instructions:

This form is used by Kaiser Permanente and/or participating providers for coverage of **Imcivree (setmelanotide).** Please complete all sections, incomplete forms will delay processing. Fax this form back to Kaiser Permanente within 24 hours fax: 1-866-331-2104. If you have any questions or concerns, please call 1-866-331-2103. **Requests will not be considered unless all sections are complete.**

KP-MAS Formulary can be found at: Pharmacy | Community Provider Portal | Kaiser Permanente

1 – Patient Information

Patient Name: _____ Kaiser Medical ID#: _____ Date of Birth: _____

2 – Prescriber Information

Is the prescriber an Endocrinologist or Pediatric Endocrinologist? □ No □ Yes

If consulted with a specialist, specialist name and specialty: _____

Prescriber Name: _____ Specialty: _____ NPI: _____

Prescriber Address: _____

Prescriber Phone #: _____Prescriber Fax #: _____

3 – Pharmacy Information

Pharmacy Name: _____ Pharmacy NPI: _____

Pharmacy Phone #_____ Pharmacy Fax #: _____

4 – Drug Therapy Requested

Drug 1: Name/Strength/Formulation: _____
Sig: _____

Drug 2: Name/Strength/Formulation: _____
Sig: _____

5– Diagnosis/Clinical Criteria

1. Is this request for initial or continuing therapy?
   □ Initial therapy □ Continuing therapy, State date: _____

2. Indicate the patient's diagnosis for the requested medication: _____

Clinical Criteria:

1. Member is ≥ 6 years of age**,**
   □ No □ Yes

2. AND has a diagnosis of obesity due to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency confirmed by genetic testing demonstrating variants in POMC, PCSK1, or LEPR genes that are interpreted as pathogenic or likely pathogenic*
   □ No □ Yes

3. AND documentation of the following:
   a. Member's BMI is ≥30 kg/m2 (adults) or ≥95th percentile (pediatric patients)
   □ No □ Yes

   b. AND alternative weight management options (diet, exercise, bariatric surgery) have failed to provide at least a 10% weight reduction,
   □ No □ Yes

   c. AND provide baseline body weight and BMI
   BMI: _____ Weight:_____

**Note: if VUS (variant of uncertain significance, test results are deemed to be highly suspicious by a medical geneticist*

For continuation of therapy, please respond to <u>additional questions</u> below.

1. Provide baseline body weight and BMI:
   Baseline BMI: _____ Weight:_____

2. Provide current BMI and body weight:
   Current BMI: _____ Weight:_____

3. Therapy should be discontinued if the patient meets **<u>any</u>** of the following criteria:

   a. Failure to reduce at least 5% of baseline body weight, or 5% of baseline BMI for patients with continued growth potential
   □ No □ Yes

   b. Diagnosed with melanoma
   □ No □ Yes

   c. Patient is breastfeeding
   □ No □ Yes

   d. Intolerance to medication
   □ No □ Yes

   e. Non-adherence to medication, recommended diet and lifestyle measures, or follow-up labs and assessments
   □ No □ Yes

   f. Documentation of suicidal thoughts or behaviors
   □ No □ Yes

   g. Pregnancy (unless benefit of treatment outweighs risk)
   □ No □ Yes

6 – Prescriber Sign-Off

Additional Information –

1. **Please submit chart notes/medical records for the patient that are applicable to this request.**
2. **If member has not tried preferred agent(s) please provide rationale/explanation and any additional supporting information that should be taken into consideration for the requested medication:**

_____

_____

_____

I certify that the information provided is accurate. Supporting documentation is available for State audits.

Prescriber Signature:	**Date:**