Print Reset

# NYRx the Medicaid Pharmacy Program

## IMCIVREE Prior Authorization Worksheet

**Fax this form to 1-800-268-2990**

Processing may be delayed if information submitted is illegible or incomplete.

### ENROLLEE INFORMATION

Enrollee Last Name: _____

Enrollee First Name: _____

Enrollee Medicaid ID (2 letters, 5 numbers, 1 letter): _____

Date of Birth: _____

### PRESCRIBER INFORMATION

Prescriber Last Name: _____

Prescriber First Name: _____

National Provider Identifier (NPI) Number: _____

Board Certified Specialty: _____

Prescriber Street Address: _____

City: _____ State: _____ Zip Code: _____

Prescriber Phone: _____ Prescriber Fax: _____

### REQUESTED DRUG INFORMATION

Drug Name: _____

Drug Strength: _____

Quantity: _____ Number of Refills: _____

Directions: _____

Is this a New Prescription?

☐ Yes ☐ No

If **No**, date therapy was initiated: _____

Enrollee's Name (Last, First): _____

**CRITERIA**

1. Please specify the prescriber's specialty:

   ☐ Endocrinologist

   ☐ Geneticist

   ☐ Physician with expertise in the diagnosis & management of patients with metabolic disorders

   ☐ Other. Please document the prescriber's specialty: _____

2. What diagnosis is this medication being prescribed for?

   ☐ Treatment of obesity due to Bardet-Biedl Syndrome (BSS)

   ☐ Treatment of obesity due to Pro-opiomelanocortin (POMC)

   ☐ Treatment of obesity due to Proprotein convertase subtilisin/kexin type 1 (PCSK1)

   ☐ Treatment of obesity due to Leptin receptor (LEPR) deficiency

   ☐ Other diagnosis:_____

   ICD-10 diagnosis code: _____

   Please provide clinical rationale for requesting Imcivree for a diagnosis that is not FDA-approved (submit clinical literature supporting Imcivree for the requested off-label indication):

3. Is the patient greater than or equal to 2 years of age?

   ☐ Yes ☐ No

   If **No**, what is the clinical reason for use under 2 years of age? (submit clinical literature demonstrating the safety and efficacy of Imcivree for pediatric patients under 2 years of age.

4. Document Baseline BMI: _____

5. Document Current BMI: _____

Enrollee's Name (Last, First): _____

**INITIATION OF THERAPY**

Attach relevant lab results, tests and diagnostic studies performed that support use of therapy.

**For obesity due to Bardet-Biedl Syndrome**

6. Is there a documented diagnosis of Bardet-Biedl Syndrome confirmed via genetic testing?

   ☐ Yes ☐ No

7. For patients ≤ 18 years of age, is BMI ≥ 97th percentile

   ☐ Yes ☐ No

   **If No**, please provide rationale for use despite not meeting the above listed parameter(s):

8. For patients ≥19 years of age, is BMI ≥30 kg/m2 **AND** patient has a history of childhood obesity?

   ☐ Yes ☐ No

   **If No**, please provide rationale for use despite not meeting the above listed parameter(s):

**For Pro-Opiomelanocortin (POMC), Proprotein Convertase Subtilisin/Kexin type 1 (PCSK1), or Leptin Receptor (LEPR)**

9. Is there a documented diagnosis of POMC, PCSK1, OR LEPR confirmed via genetic testing?

   ☐ Yes ☐ No

   Test results are required to be submitted via fax that demonstrate variants in POMC, PCSK1, or LEPR genes that are interpreted as **pathogenic, likely pathogenic, or of uncertain significance** (VUS). Can these test results be faxed?

   ☐ Yes ☐ No

   **If No,** please provide clinical reason for use without confirmed genetic test results:

Enrollee's Name (Last, First): _____

10. For patients ≤18 years of age, is BMI ≥95th percentile?

☐ Yes ☐ No

**If No**, please provide rationale for use despite not meeting the above listed parameter(s):

11. For patients ≥19 years of age, is BMI ≥30 kg/m$^2$ **AND** patient has a history of childhood obesity?

☐ Yes ☐ No

**If No**, please provide rationale for use despite not meeting the above listed parameter(s):

## CONTINUATION OF THERAPY

### For Bardet-Biedl Syndrome (BBS)

12. Has the patient demonstrated a positive response to therapy, as evidenced by weight reduction of either of the following:
    a. For patients ≤18 years of age, weight loss of ≥ 5% of baseline BMI or ≥ 5% of baseline body weight; OR
    b. For patient ≥19 years of age, a weight loss of ≥ 5% of baseline body weight

    ☐ Yes ☐ No

    **If No**, please provide rationale for continued use (Note: If a patient has not lost at least 5% of baseline body weight, or 5% of baseline BMI it is recommended to discontinue Imcivree):

### For Pro-opiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency

13. Has the patient demonstrated a positive response to therapy, as evidenced by weight reduction of ≥ 5% of baseline body weight or ≥ 5% of baseline BMI for patients with continued growth potential?

    ☐ Yes ☐ No

    **If No**, please provide rationale for continued use (Note: If a patient has not lost at least 5% of baseline body weight, or 5% of baseline BMI for patients with continued growth potential it is recommended to discontinue Imcivree):

Enrollee's Name (Last, First): _____

Submission of this form confirms the information is accurate and true, and that the supporting documentation is available for review upon request of the NYSDOH or CMS. The submitter understands that any person who knowingly makes or causes to be made a false record to statement that is material to a Medicaid claim may be subject to civil penalties and treble damages under both federal and NYS False Claims Acts.

**Fax Number: 800-268-2990**

**Billing Questions: 800-343-9000**

For clinical concerns or Preferred Drug Program questions, please visit http://newyork.fhsc.com or call 877-309-9493.