

IMCIVREE

PRIOR AUTHORIZATION REQUEST

PRESCRIBER FAX FORM

Only the prescriber may complete this form. This form is for prospective, concurrent, and retrospective reviews.

The following documentation is **REQUIRED**. Incomplete forms will be returned for additional information. For formulary information please visit www.myprime.com. Start saving time today by filling out this form electronically. Visit covermymeds.com to begin using this free service.

What is the priority level of this request?

- Standard review
- Expedited/Urgent review – prescriber certifies that waiting for a standard review could seriously harm the patient's life, health or ability to regain maximum function

Today's Date: _____

PATIENT AND INSURANCE INFORMATION

Date of Service (if differs from Today's Date): _____

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
Patient Address:	City, State, Zip:	Patient Telephone:	
Member ID Number:	Group Number:		

PRESCRIBER/CLINIC INFORMATION

Prescriber Name:	Prescriber NPI#:	Specialty:	Contact Name:
Clinic Name:	Clinic Address:		
City, State, Zip:	Phone #:	Secure Fax #:	

PLEASE ATTACH ANY ADDITIONAL INFORMATION THAT SHOULD BE CONSIDERED WITH THIS REQUEST

Patient's Diagnosis: <input type="checkbox"/> Monogenic obesity due to proopiomelanocortin (POMC) deficiency, proprotein convertase subtilisin/kexin type 1 (PCSK1) deficiency, or leptin receptor (LEPR) deficiency <input type="checkbox"/> Syndromic obesity due to Bardet-Biedl syndrome (BBS) <input type="checkbox"/> Other (ICD code, plus description): _____	
Medication Requested:	Strength:
Dosing Schedule:	Quantity per Month:
For all requests: 1. Is the patient currently treated with the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when was treatment with the requested agent started? _____ 2. Does the patient have any FDA labeled contraindications to the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify contraindications: _____ _____ 3. Is the patient's age within FDA labeling for the requested indication for the requested agent?..... <input type="checkbox"/> Yes <input type="checkbox"/> No If no, please provide support for using the requested agent for the patient's age for the requested indication: _____ _____ 4. Is the prescriber a specialist in the area of the patient's diagnosis (e.g., endocrinologist, geneticist, metabolic disorders), or has the prescriber consulted with a specialist in the area of the patient's diagnosis?..... <input type="checkbox"/> Yes <input type="checkbox"/> No 5. Is the patient an adult? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient's body mass index (BMI) is greater than or equal to 30 kg/m ² ? <input type="checkbox"/> Yes <input type="checkbox"/> No 6. Is the patient a pediatric patient? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, is the patient's weight greater than or equal to 95th percentile (for POMC, PCSK1, or LEPR) or 97th percentile (for BBS) using growth chart assessments? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Please continue to the next page.	

Patient Name (First):	Last:	M:	DOB (mm/dd/yyyy):
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7. Please list all reasons for selecting the requested agent for the indicated diagnosis, strength, dosing schedule, and quantity over alternatives (e.g., compendia support, journal articles, contraindications, allergies, history of adverse drug reactions to alternatives, lower dose has been tried, information supporting dose over FDA max). **Please note, documentation may be required:** _____

For obesity due to POMC, PCSK1, or LEPR deficiency requests:

8. Has genetic testing with an FDA-approved test confirmed variants in POMC, PCSK1, or LEPR genes? **Please note, medical records are required.** Yes No
9. Is the patient's genetic status bi-allelic, homozygous, or compound heterozygous (NOT double heterozygous)? Yes No
10. Is the patient's genetic variant interpreted as pathogenic, likely pathogenic, OR of uncertain significance (VUS)? Yes No
11. Is the patient's genetic variant NOT classified as benign or likely benign? Yes No
12. Is the patient newly starting therapy? Yes No
 If no, is the patient currently being treated and has received less than 16 weeks (4 months) of therapy? Yes No
 If no, has the patient received at least 16 weeks of therapy, and has achieved and maintained a weight loss of ONE of the following: 1) weight loss of greater than or equal to 5% of baseline body weight (prior to the initiation of the requested agent), OR, 2) for patients with continued growth potential, weight loss of greater than or equal to 5% of baseline BMI (prior to the initiation of the requested agent)? Yes No

For obesity due to BBS requests:

13. Has the patient's diagnosis been clinically confirmed by four primary features OR three primary and two secondary features (i.e., primary features [rod-cone dystrophy, polydactyly, obesity, genital anomalies, renal anomalies, learning difficulties]; secondary features [speech delay, developmental delay, diabetes mellitus, dental anomalies, congenital heart disease, brachydactyly/syndactyly, ataxia/poor coordination, anosmia/hyposmia])? **Please note, medical records are required.** Yes No
14. Is the patient newly starting therapy? Yes No
 If no, is the patient currently being treated and has received less than one year of therapy? Yes No
 If no, has the patient received at least one year of therapy and has achieved a weight loss of ONE of the following: 1) weight loss of greater than or equal to 5% of baseline body weight (prior to initials of the requested agent), or 2) for patients aged less than 18 years, weight loss of greater than or equal to 5% of baseline BMI (prior to the initiation of the requested agent)? Yes No

For renewal requests:

15. Is the patient an adult? Yes No
 If yes, has the patient achieved and maintained weight loss of greater than or equal to 5% of baseline body weight (prior to initiation of the requested agent)? Yes No
16. Does the patient have continued growth potential? Yes No
 If yes, has the patient achieved and maintained weight loss of greater than or equal to 5% of baseline BMI (prior to the initiation of the requested agent)? Yes No

Please fax or mail this form to:
 Prime Therapeutics LLC
 Clinical Review Department
 2900 Ames Crossing Road Suite 200
 Eagan, MN 55121

TOLL FREE

Phone: **Fax: 877.243.6930**
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BCBSNM: 800.544.1378
BCBSOK: 800.991.5643
BCBSTX: 800.289.1525

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