



# New Hampshire Medicaid Fee-for-Service (FFS) Program

## Prior Authorization Drug Approval Form

Imcivree™ (setmelanotide)

DATE OF MEDICATION REQUEST:     /     /

### SECTION I: PATIENT INFORMATION AND MEDICATION REQUESTED

LAST NAME:

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FIRST NAME:

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MEDICAID ID NUMBER:

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DATE OF BIRTH:

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GENDER: ☐ Male ☐ Female

Drug Name

Strength

Dosing Directions

Length of Therapy

### SECTION II: PRESCRIBER INFORMATION

LAST NAME:

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FIRST NAME:

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SPECIALTY:

NPI NUMBER:

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PHONE NUMBER:

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FAX NUMBER:

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### SECTION III: CLINICAL HISTORY

- Does the patient have a BMI 30 kg/m<sup>2</sup> or more or in the 95th or higher percentile on the pediatric growth chart? ☐ Yes ☐ No
- Does the patient have a diagnosis of proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency, as confirmed by a genetic test? ☐ Yes ☐ No
- Is the genetic variant pathogenic, likely pathogenic, or of uncertain significance? ☐ Yes ☐ No
- Does the patient have a diagnosis of Bardet-Biedl Syndrome? **If yes, select all that apply.** ☐ Yes ☐ No  
☐ Intellectual impairment ☐ Renal anomalies ☐ Polydactyly  
☐ Retinal degeneration ☐ Genital anomalies
- Is the prescriber an endocrinologist or geneticist, or has one been consulted? ☐ Yes ☐ No
- Is there any additional information that would help in the decision-making process?  
If additional space is needed, please use a separate sheet.

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**Prior Authorization Drug Approval Form**  
Imcivree™ (setmelanotide)

**PATIENT LAST NAME:**

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**PATIENT FIRST NAME:**

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**SECTION III: CLINICAL HISTORY** *(continued)*

Baseline body weight: \_\_\_\_\_ Renewal body weight: \_\_\_\_\_

I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

**PRESCRIBER'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_