PRIOR AUTHORIZATION REQUEST FORM

Individual and Family Plans

Imcivree

Fax back to: (833) 605-4407

Phone: (215) 991-4300

Jefferson Health Plans manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above.

PLEASE NOTE: Any information (patient, prescriber, drug, labs) left blank, illegible, or not attached WILL delay the review process.

Patient Name:	**Prescriber Name:**
Member Number:	Fax: Phone:
Date of Birth:	Office Contact:
Line of Business: ☐ Exchange - PA	NPI: State Lic ID:
Address:	Address:
City, State ZIP:	City, State ZIP:
Primary Phone:	**Specialty/facility name (if applicable):**

☐ REQUEST FOR EXPEDITED REVIEW: By checking this box and signing below, I certify that the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

Drug Name:	
Strength:	
Directions / SIG:	

Please attach any pertinent medical history including labs and information for this member that may support approval.
Please answer the following questions and sign.

Q1. Is the patient at least 2 years of age or older?

☐ Yes ☐ No

Q2. Does the patient meet ONE of the following:

a. Have a clinical diagnosis of Bardet-Biedl syndrome (BBS)
b. Have genetic testing that demonstrates homozygous or compound heterozygous mutations in one of the following genes: POMC, PCSK1, or LEPR and the genetic variant is interpret as pathogenic, likely pathogenic, or of uncertain significance

☐ Yes ☐ No

Q3. Does the patient meet one of the following criteria (a, b, or c):
a. Individual is 18 years of age: BMI 30 kg/m2
b. Individual is 6 to 17 years of age and has POMC, PSCK1, or LEPR deficiencies: BMI 95th percentile for age and sex
c. Individual is 6 to 17 years of age and has BBS: BMI 97th percentile for age and sex

☐ Yes ☐ No

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Patient Name:	**Prescriber Name:**

Q4. Does the patient have documentation of counseling regarding lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity)?

☐ Yes ☐ No

Q5. Is Imcivree prescribed by or in consultation with an endocrinologist, a geneticist, or a physician who specializes in metabolic disorders?

☐ Yes ☐ No

Q6. FOR RENEWAL:
Does the patient meet one of the following criteria (a, b, or c):
a. Patient has lost 5% of baseline body weight since initiating Imcivree therapy
b. Patient meets both of the following (1 and 2)
i. Patient has continued growth potential
ii. Patient has lost 5% of baseline BMI since initiating Imcivree therapy;
c. Patient is receiving clinical benefit based on the prescriber's assessment.

☐ Yes ☐ No

Q7. Is the medication well tolerated without major side effects?

☐ Yes ☐ No

Q8. Additional Information:

______________________________ ____________________

Prescriber Signature Date

v2026

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