



HEALTH PARTNERS PLANS
PRIOR AUTHORIZATION REQUEST FORM

Health Partners Plans

Imcivree

Phone: 215-991-4300

Fax back to: 866-240-3712

Health Partners 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.

Form with fields: Patient Name, Prescriber Name, HPP Member Number, Date of Birth, Patient Primary Phone, Address, City, State ZIP, Line of Business, Drug Name, Quantity, Directions, Diagnosis Code, Diagnosis, etc.

HPP's maximum approval time is 12 months but may be less depending on the drug.

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 this a renewal? If the patient has completed at least 4 months of therapy, go to 7.

Yes No

Q2. Is the patient at least 6 years of age or older?

Yes No

Q3. Does the patient meet ONE of the following?

- A) Have a clinical diagnosis of Bardet-Biedl syndrome (BBS) OR
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

Q4. Does the patient meet one of the following criteria?

- A) Individual is >= 18 years of age: BMI >= 30 kg/m2 OR
B) Individual is 6 to 17 years of age and has POMC, PSCK1, or PEPR deficiencies: BMI >= 95th percentile for age and sex OR
C) Individual is 6 to 17 years of age and has BBS: BMI >= 97th percentile for age and sex

Yes No

Q5. Does the patient have documentation of counseling regarding lifestyle changes and behavioral modification (e.g., healthy diet and increased physical activity)?

Yes No

This telecopy transmission contains confidential information belonging to the sender that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing this information to any other party.



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Patient Name: Prescriber Name:

Q6. Is ImcivreeTM prescribed by or in consultation with an endocrinologist, a geneticist, or a physician who specializes in metabolic disorders?

Yes No

Q7. Does the patient meet ONE of the following criteria?

- A) Patient has lost >= 5% of baseline body weight since initiating ImcivreeTM therapy
B) Patient meets both of the following (1 and 2)
1) Patient has continued growth potential
2) Patient has lost >= 5% of baseline BMI since initiating ImcivreeTM therapy;
C) Patient is receiving clinical benefit based on the prescriber's assessment.

Yes No

Q8. Is the medication well tolerated without major side effects?

Yes No

Q9. Additional Information:

Prescriber Signature

Date

Updated for 2023