| Reference number(s) |
| --- |
| 4378-A |

# SPECIALTY GUIDELINE MANAGEMENT

## IMCIVREE (setmelanotide)

**POLICY**

### I. INDICATIONS

The indications below including FDA-approved indications and compendial uses are considered a covered benefit provided that all the approval criteria are met and the member has no exclusions to the prescribed therapy.

FDA-Approved Indications
Imcivree is indicated for chronic weight management in adult and pediatric patients 6 years of age and older with obesity due to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency confirmed by genetic testing demonstrating variants in *POMC*, *PCSK1*, or *LEPR* genes that are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS).

Limitations of Use:

Imcivree is not indicated for the treatment of patients with the following conditions as Imcivree would not be expected to be effective:
a. Obesity due to suspected POMC, PCSK1, or LEPR deficiency with *POMC*, *PCSK1*, or *LEPR* variants classified as benign or likely benign
b. Other types of obesity not related to POMC, PCSK1, or LEPR deficiency, including obesity associated with other genetic syndromes and general (polygenic) obesity

All other indications are considered experimental/investigational and not medically necessary.

### II. DOCUMENTATION

Submission of the following information is necessary to initiate the prior authorization review:
A. Initial Requests:
   1. Genetic test results documenting homozygous or compound heterozygous variants in *POMC*, *PCSK1*, or *LEPR* genes
   2. Medical record (e.g., chart notes) and growth chart (in members less than 18 years of age) documentation of pretreatment Body Mass Index (BMI) and weight
B. Continuation Requests (where applicable): Medical record (e.g., chart notes) and growth chart (if continued growth potential) documentation of current Body Mass Index (BMI) and current weight

### III. CRITERIA FOR INITIAL APPROVAL

**Obesity Due To POMC, PCSK1, or LEPR Deficiency**
Authorization of 6 months may be granted for treatment of chronic weight management in members with obesity due to proopiomelanocortin (POMC), proprotein convertase subtilisin/kexin type 1 (PCSK1), or leptin receptor (LEPR) deficiency when all of the following criteria are met:

A. Diagnosis is confirmed by genetic testing demonstrating homozygous or compound heterozygous variants in *POMC*, *PCSK1*, or *LEPR* genes
B. *POMC, PCSK1*, or *LEPR* gene variants are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS)
C. The member is 6 years of age or older
D. The member has obesity defined as one of the following:
    1. BMI greater than or equal to 30 kg/m$^2$ in members 18 years of age or older
    2. BMI greater than or equal to 95$^{th}$ percentile for age on growth chart assessment in members less than 18 years of age

## IV. CONTINUATION OF THERAPY

Authorization of 12 months may be granted for continued treatment in members requesting reauthorization for an indication listed in Section III when one of the following is met:

A. The member has received less than 12 months of therapy and one of the following is met:
    1. Member has lost at least 5% of baseline body weight
    2. Member has continued growth potential and has had a reduction in Body Mass Index (BMI) of at least 5% from baseline
B. Member has received 12 months of therapy or more and has achieved or sustained clinically meaningful weight loss

## V. REFERENCES

1. Imcivree [package insert]. Boston, MA: Rhythm Pharmaceuticals, Inc; November 2020.
2. Clément K, van den Akker E, Argente J, et al. Efficacy and safety of setmelanotide, an MC4R agonist, in individuals with severe obesity due to LEPR or POMC deficiency: single-arm, open-label, multicentre, phase 3 trials. Lancet Diabetes Endocrinol. 2020;8(12):960-970.