IMCIVREE™ Start Form
(setmelanotide) injection

Fax forms to 1-877-805-0130 | Phone: 1-844-YOUR-GPS (1-844-968-7477)

Prescriber information | **Prescriber to complete pages 1 and 2 (patient to complete page 3)**

Step 1 Patient information

Patient name (first, middle initial, last): _____

DOB (MM/DD/YYYY): _____ Last 4 digits of patient SSN: _____

Preferred language: ☐ English ☐ Spanish ☐ Other: _____ Phone number: _____

Caregiver name: _____

Relationship to patient: _____ Caregiver phone: _____

Step 2 Insurance information

Does patient have insurance: ☐ Yes ☐ No (If yes, please select): ☐ Medicare Plan ☐ Medicaid Plan ☐ Private Insurance

Attach a copy of both sides of the patient's INSURANCE and PRESCRIPTION card or fill out the information below.

Primary insurance provider:	Employer name:	Policy number:		Group number:
Policyholder name (first, middle initial, last), if other than the patient:		Policyholder date of birth (MM/DD/YYYY):		Insurance phone:
Pharmacy plan provider (if applicable):	Policy number:	Group number:	Rx BIN number:	Rx PCN number:
Policyholder name (first, middle initial, last), if other than the patient:		Policyholder date of birth (MM/DD/YYYY):		Insurance phone:
Secondary insurance provider (if applicable):	Employer name:	Policy number:		Group number:
Policyholder name (first, middle initial, last), if other than the patient:		Policyholder date of birth (MM/DD/YYYY):		Insurance phone:

Step 3 Diagnosis and clinical information

Diagnosis must be confirmed by genetic test demonstrating variants in *POMC*, *PCSK1*, or *LEPR* genes that are interpreted as pathogenic, likely pathogenic, or of uncertain significance (VUS). **Attach a copy of the genetic test results.**

☐ Obesity due to POMC (proopiomelanocortin) deficiency

☐ Obesity due to PCSK1 (proprotein convertase subtilisin/kexin type 1) deficiency

☐ Obesity due to LEPR (leptin receptor) deficiency

☐ Other (specify): _____

Current weight of patient (lbs): _____

Current height of patient (in): _____

Date (MM/DD/YYYY): _____

Previous treatments for obesity: _____

Current medication list (attach extra page if necessary): _____

Step 4 Prescriber information

Name (first, middle initial, last): _____ Specialty: _____

Practice name: _____

Street: _____ City: _____ State: _____ ZIP: _____

Prescriber NPI† #: _____

Office contact: _____ Phone: _____ Fax: _____

†National Provider Identifier.

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Prescriber information — Prescriber to complete pages 1 and 2 (patient to complete page 3)

Patient name (first, middle initial, last): _____ DOB (MM/DD/YYYY): _____

Step 5 — Prescription information

Pediatric patients aged 6 to less than 12 years

- The starting dose of IMCIVREE is 1 mg (0.1 mL) injected subcutaneously once daily for 2 weeks.
- If the starting dose is not tolerated, reduce to 0.5 mg (0.05 mL) once daily. If the 0.5 mg daily dose is tolerated, and additional weight loss is desired, titrate to 1 mg (0.1 mL) once daily.
- If the 1 mg dose is tolerated, increase the dose to 2 mg (0.2 mL) once daily.
- If the 2 mg once daily dose is not tolerated, reduce to 1 mg (0.1 mL) once daily. If the 2 mg daily dose is tolerated, and additional weight loss is desired, the dose may be increased to 3 mg (0.3 mL) once daily.

Adults and pediatric patients 12 years of age and older

- The starting dose of IMCIVREE is 2 mg (0.2 mL) injected subcutaneously once daily for 2 weeks.
- If the starting dose is not tolerated, reduce to 1 mg (0.1 mL) once daily. If the 1 mg daily dose is tolerated, and additional weight loss is desired, titrate to 2 mg (0.2 mL) once daily.
- If the 2 mg daily dose is tolerated, increase the dose to 3 mg (0.3 mL) once daily. If the 3 mg daily dose is not tolerated, maintain administration of 2 mg (0.2 mL) once daily.

Please check the appropriate boxes for your patient's AGE and MAINTENANCE dose.

Age	Schedule	Quantity	Refills (#)
☐ **6 to less than 12 years**	**Titration** ☐ 1 mg (0.1 mL) subq once daily for 2 weeks; 2 mg (0.2 mL) subq once daily ☐ No titration needed	Dispense number of vials sufficient for up to 30-day supply	N/A
	Additional titration instructions		
	Maintenance (select one) ☐ 0.5 mg (0.05 mL) subq once daily ☐ 1 mg (0.1 mL) subq once daily ☐ 2 mg (0.2 mL) subq once daily ☐ 3 mg (0.3 mL) subq once daily	Dispense number of vials sufficient for up to 30-day supply	
☐ **12 years and older**	**Titration** ☐ 2 mg (0.2 mL) subq once daily for 2 weeks; 3 mg (0.3 mL) subq once daily ☐ No titration needed	Dispense number of vials sufficient for up to 30-day supply	N/A
	Additional titration instructions		
	Maintenance (select one) ☐ 1 mg (0.1 mL) subq once daily ☐ 2 mg (0.2 mL) subq once daily ☐ 3 mg (0.3 mL) subq once daily	Dispense number of vials sufficient for up to 30-day supply	

How supplied: IMCIVREE is supplied as a 10-mg/mL solution in a 1-mL multiple-dose vial: NDC 72829-010-01.

Step 6 — Healthcare provider certification

I certify that the information provided in this IMCIVREE Start Form is complete and accurate to the best of my knowledge. I have prescribed IMCIVREE based on my judgment of medical necessity, as documented in the patient's medical record, and I will supervise the patient's medical treatment. I certify I have obtained the above referenced patient's written authorization in accordance with applicable state and federal laws including the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations to provide the individually identifiable health information on this form to agents and service providers of Rhythm Pharmaceuticals, Inc., including but not limited to IMCIVREE dispensing pharmacies, for benefits eligibility, coverage authorization, and coordination and dispensing of IMCIVREE. I authorize the forwarding of this Start Form (and the information included herein) to PANTHERx Specialty Pharmacy. I understand that enrollment of the above referenced patient in IMCIVREE GPS is not a guarantee of coverage or access to IMCIVREE (including to free product or copayment assistance) and that the sole purpose of this Support Service is to help to facilitate improved access and product support to the patient. I understand that, to the extent that any free product is furnished to the patient, neither I nor the patient may seek reimbursement for any such free product received under any IMCIVREE program. I also understand that the patient is not eligible for copay assistance, should any be available, if he/she is enrolled in any federal healthcare program. If the patient has requested a shipment to my office, I agree not to receive any compensation for dispensing the product and I will clearly label and dispense only for use by the patient referenced on this application.

Sign, date, and fax to 1-877-805-0130

_____

Prescriber signature — dispense as written (Original signature required) Date (MM/DD/YYYY)

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Patient information — Patient or legally authorized representative to complete this page

Patient name (first, middle initial, last): _____

Date of birth (MM/DD/YYYY): _____ Last 4 digits of patient SSN: _____

Preferred language: ☐ English ☐ Spanish ☐ Other: _____ Gender: ☐ Male ☐ Female ☐ Non-binary

Street: _____ City: _____ State: _____ ZIP: _____

Home phone: _____ Cell phone: _____ Preferred: ☐ Home ☐ Cell

☐ OK to leave a detailed message? ☐ OK to send a text? Email: _____

Name of person completing form: _____

Relationship to patient: _____ Phone: _____

Section A — Authorization to share personal health information

Patient or legal representative authorization to share personal health information

I authorize any health plan, physician, health care professional, hospital, clinic, pharmacy provider or other health care provider (collectively, "Providers") to disclose my personal health information, including personal information relating to my medical condition, genetic test results, treatment, care management, and health insurance, as well as all information provided on this form and any prescription ("Information"), to Rhythm Pharmaceuticals, Inc., its affiliates and their representatives, agents, and contractors (collectively, the "Company" or "Rhythm") in connection with the Company's provision of products, supplies, or services. I authorize the Company to provide this Information to a specialty pharmacy to fulfill the prescription. This Information may also be used for internal purposes by the Company, including data analysis, or to improve, develop, and evaluate products, services, and programs related to my condition. I understand that the specialty pharmacy may receive payment for the expense of assembling and sending data about me to the Company.

Further, the Company may use and disclose this Information for IMCIVREE GPS Support Services (if I agree below) such as verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, other related programs, communication with me or my prescribing physician by mail, email, or telephone about my medical condition, treatment, care management, product information, and health insurance.

I understand that once disclosed to the Company, my Information disclosed under this Authorization may no longer be protected by federal privacy law, including HIPAA. I understand that I am entitled to a copy of this Authorization. I understand that I may cancel this Authorization at any time by sending written notice of revocation to Rhythm Pharmaceuticals, Inc., 222 Berkeley Street, 12th Floor, Boston, MA 02116. I understand that such revocation will not apply to any information already used or disclosed through this Authorization. I understand that revoking my authorization will end my participation in the IMCIVREE GPS Support Services. This Authorization will remain in effect for five (5) years from today's date, unless a shorter period is provided for by state law. I understand that I may refuse to sign this Authorization and that refusing to sign this Authorization will not change the way my physician, health insurance, and pharmacy providers treat me. I also understand that if I do not sign this Authorization, I will not be able to receive IMCIVREE GPS Support Services.

IMCIVREE GPS (Guidance · Partnership · Support) Support Services program enrollment

☐ I am electing to enroll in the IMCIVREE GPS Support Services ("Service") and direct all disclosures of my Information in connection with such Service (which may include, but are not limited to, verification of insurance benefits and drug coverage, prior authorization support, financial assistance with co-pays, patient assistance programs, alternate funding sources, and other related programs). I authorize Rhythm and its representatives, agents, and contractors to provide me with Service. I also authorize Rhythm to contact me or my physician by mail, email, or telephone in connection with the Service. The Company may also share information with my healthcare team for my care.

Sign and date here

_____ Patient/legal representative signature

_____ Date (MM/DD/YYYY)

_____ Patient name

_____ Legal representative name and relationship

Section B — Consent for educational information

☐ By checking this box, I (or my representative) also authorize Rhythm and certain authorized parties to send me educational communications such as mailings, emails, newsletters about the product or IMCIVREE GPS Support Services, or occasional communication for market research purposes. I understand that I may opt out of these communications at any time via the link/contact information available in all communications.