Prior Authorization Request

Date of Request ________________

Serostim

Serostim (Somatropin) is Human Growth Hormone indicated for HIV/AIDS-Wasting Syndrome.

Patient has no malignant lesion; antiretroviral therapy optimized; involuntary weight loss ≥ 10 %; failed to increase muscle mass on megestrol acetate (or intolerant). [3 months]

Reevaluate for increase in muscle mass and weight. [3 months]

Member Information

Name ________________

Enrollment / Cardholder ID ________________

Group / Plan ________________

Birth date ________________

Address: ________________

City State Zip ________________

Relationship (Circle)

Subscriber **Spouse** **Dependent**

Gender (Circle)

Male **Female**

AGE: ________ **Weight (kg):** ___________

Practitioner Information

Name ________________

Agent / Contact Name ________________

Specialty ________________

Office / Clinic Name ________________

Address ________________

City State Zip ________________

Phone (   ) - ________________

Fax (   ) - ________________

ID Number ________________

Email ________ @ ________

Megestrol acetate? **Y** **N**

Weight ________________

Requested Drug / Pharmaceutical

Serostim (Somatropin)

Strength / Dose

Therapy Start Date

Condition / Diagnosis Related - Reason for Request

Duration of Therapy (Expected)

Type of Request (Circle)

One-Time **On-Going**

Clinical Drug / Lab History Pertinent to Request

Labs: **Baseline / Ongoing**

Formulary Alternative(s) Attempted **YES** **NO** (Circle)

Please List:

Contact Pharmacy? **Y** **N**

Pharmacy Phone Number

____

Practitioner Signature

Date Received:
Reviewed By:
Forwarded To:

FAX Form to:
877-800-5633

HT Clinical Services Phone
866-805-1690