Physician SEROSTIM® Prior Authorization Request Form

Fax to Pharmacy Services at **855-811-9332,** or to speak to a Representative, call **888-602-3741**. *Form must be completed for processing.*

Patient Name: ______________________ Patient ID#: ______________________

Address: ______________________ Apt # or Suite #: ______________________

City: ______________________ State: __________ Zip Code: ______________________

Phone #: ______________________ Birth date:______________________

Physician Name: ______________________ License #: ______________________

Address: ______________________ Apt # or Suite #: ______________________

City: ______________________ State: __________ Zip Code: ______________________

Contact Person: ______________________ Phone #: ______________ Fax #: ______________________

Physician Signature______________________

Deliver to:
☐ **Physician's Office** ☐ **Patient's Home** ☐ **Patient filling at local Pharmacy (Name)** ______________________ **Fax:** ______________

To be Administered from: ____________ to ____________ or on:____________

Drug Name: ______________________ Diagnosis: ______________________

Sig (How Administered): ______________________ ICD-9 Diagnosis Code: ______________________

Provide documentation (Attach BIA analysis report) of Body Impedance Analysis (BIA) including Body Cell mass and BMI.
Height:________________ Weight:______________lb ______________kg

1. Does the member currently have HIV/AIDS? (please circle) YES NO
   If YES, please attach documentation from an infectious disease doctor indicating that the member is receiving optimal antiviral therapy or recent (within the past 2 months) laboratory documentation indicating plasma HIV RNA of less than 50 copies/ml:

2. Does the member currently have cancer (excluding Karposi's sarcoma)? (please circle) YES NO
   If YES, please explain ____
   ____

3. Does the member currently have any symptomatic, opportunistic infections causing GI distress (e.g. diarrhea, N/V, etc.)? (please circle) YES NO
   If YES, please explain ____
   ____

4. Is the member currently receiving nutritional support to reach nutritional goals? (please circle) YES NO
   If YES, please explain (e.g. oral/liquid supplement, provided meal assistance, etc.) ______________________
   ____

5. Does the member currently have any psychiatric disorders (e.g. anxiety, depression, etc)? (please circle) YES NO
   If YES, please document treatment ____
   ____

6. Is the member currently receiving an anabolic medication (Oxandrin, Winstrol, Nandrolone) AND an appetite stimulant (Marinol or Megace)? (please circle) YES NO
   If NO, please explain (e.g. Is there a medical reason for not taking both these medications?) ______________________
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7. For males, is the member currently receiving testosterone replacement therapy? (please circle) YES NO
   If NO, please attach current documentation (lab result within the past 2 months) of normal testosterone blood levels.