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Please note: All information below is required to process this request.

Mon-Fri: 5am to 10pm Pacific / Sat: 6am to 3pm Pacific

Serostim[®] Prior Authorization Request Form

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Member Information (required)			Provider Information (required)		
Member Name:			Provider Name:		
Insurance ID#:			NPI#:		Specialty:
Date of Birth:			Office Phone:		
Street Address:			Office Fax:		
City:	State:	Zip:	Office Street Address:		
Phone:			City:	State:	Zip:
Medication Information (required)					
Medication Name:			Strength:		Dosage Form:
<input type="checkbox"/> Check if requesting brand			Directions for Use:		
<input type="checkbox"/> Check if request is for continuation of therapy					
Clinical Information (required)					
Select the diagnosis below: <input type="checkbox"/> Human immunodeficiency virus (HIV)-associated wasting syndrome or cachexia <input type="checkbox"/> Other diagnosis: _____ ICD-10 Code(s): _____					
Clinical Information: Select if the patient has experienced the following: <input type="checkbox"/> Unintentional weight loss of > 10% over the last 12 months <input type="checkbox"/> Unintentional weight loss of > 7.5% over the last 6 months <input type="checkbox"/> Loss of 5% body cell mass (BCM) within 6 months <input type="checkbox"/> Body mass index (BMI) < 20 kg/m ² <input type="checkbox"/> Patient is male with BCM < 35% of total body weight and BMI < 27 kg/m ² <input type="checkbox"/> Patient is female with BCM < 23% of total body weight and BMI < 27 kg/m ² Has nutritional evaluation been done since onset of wasting first occurred? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient had weight loss as a result of other underlying treatable conditions (e.g., depression, mycobacterium avium complex, chronic infectious diarrhea, or malignancy with the exception of Kaposi's sarcoma limited to skin or mucous membranes)? <input type="checkbox"/> Yes <input type="checkbox"/> No Has the patient's anti-retroviral therapy been optimized to decrease the viral load? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Reauthorization: If this is a reauthorization request, answer the following questions: Does the patient show evidence of positive response to therapy (i.e., greater than or equal to 2% increase in body weight and/or BCM)? <input type="checkbox"/> Yes <input type="checkbox"/> No Select if the following targets or goals have been achieved: <input type="checkbox"/> Weight <input type="checkbox"/> BCM <input type="checkbox"/> BMI					

Are there any other comments, diagnoses, symptoms, medications tried or failed, and/or any other information the physician feels is important to this review?

Please note: This request may be denied unless all required information is received.
 For urgent or expedited requests please call 1-800-711-4555.
 This form may be used for non-urgent requests and faxed to 1-800-527-0531.

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