OptumRx has partnered with CoverMyMeds to receive prior authorization requests, saving you time and often delivering real-time determinations.
Visit go.covermymeds.com/OptumRx to begin using this free service.
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

DO NOT COPY FOR FUTURE USE. FORMS ARE UPDATED FREQUENTLY AND MAY BE BARCODED

Member Information (required)

Member Name:		
Insurance ID#:		
Date of Birth:		
Street Address:		
City:	State:	Zip:
Phone:		

Provider Information (required)

Provider Name:		
NPI#:	Specialty:	
Office Phone:		
Office Fax:		
Office Street Address:		
City:	State:	Zip:

Medication Information (required)

Medication Name:	Strength:	Dosage Form:
❑ Check if requesting **brand**	Directions for Use:	
❑ Check if request is for **continuation of therapy**		

Clinical Information (required)

Select the diagnosis below:

❑ Human immunodeficiency virus (HIV)-associated wasting syndrome or cachexia

❑ Other diagnosis: _____ ICD-10 Code(s): _____

Clinical Information:

Select if the patient has experienced the following:

- ❑ Unintentional weight loss of > 10% over the last 12 months
- ❑ Unintentional weight loss of > 7.5% over the last 6 months
- ❑ Loss of 5% body cell mass (BCM) within 6 months
- ❑ Body mass index (BMI) < 20 kg/m^2
- ❑ Patient is male with BCM < 35% of total body weight and BMI < 27 kg/m^2
- ❑ 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? ❑ **Yes** ❑ **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)? ❑ **Yes** ❑ **No**

Has the patient's anti-retroviral therapy been optimized to decrease the viral load? ❑ **Yes** ❑ **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)? ❑ **Yes** ❑ **No**

Select if the following targets or goals have been achieved:

- ❑ Weight
- ❑ BCM
- ❑ 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.