Prior Authorization Form

Serostim

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to CVS/Caremark at **1-888-836-0730**.
Please contact CVS/Caremark at **1-800-294-5979** with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Serostim.

Drug Name (select from list of drugs shown)
Serostim (somatropin)

Quantity Frequency Strength

Route of Administration Expected Length of Therapy

Patient Information
Patient Name: _____
Patient ID: _____
Patient Group No.: _____
Patient DOB: _____
Patient Phone:

Prescribing Physician
Physician Name: _____
Physician Phone: _____
Physician Fax: _____
Physician Address: _____
City, State, Zip: _____

Diagnosis: _____ **ICD Code:** _____

Comments: _____

Please circle the appropriate answer for each question.

1. Does the patient have an acute critical illness?	Y N
[If yes, then no further questions.]	
2. Does the patient have an active malignancy or history of malignancy in the past 12 months?	Y N
[If yes, then no further questions.]	
3. Does the patient have a diagnosis of cachexia or wasting syndrome associated with human immunodeficiency virus (HIV) infection?	Y N
[If no, then no further questions.]	

4.	Has the patient tried and had a suboptimal response to alternative therapies (eg, megestrol or dronabinol)?	Y N
	[If no, then no further questions.]	
5.	Have alternative causes of wasting such as inadequate nutritional intake, malabsorption, opportunistic infections, or hypogonadism been ruled out or treated appropriately?	Y N
	[If no, then no further questions.]	
6.	Is Serostim used in combination with antiretroviral therapy?	Y N
	[If no, then no further questions.]	
7.	Is the patient currently on somatropin?	Y N
	[If no, skip to question 9.]	
8.	Has the patient received at least 12 weeks of somatropin therapy during this current round of treatment?	Y N
	[If yes, skip to question 10.]	
	[If no, no further questions.]	
9.	Has the patient received previous round(s) of somatropin therapy?	Y N
	[If no, then no further questions.]	
10.	Has the patient's body mass index (BMI) improved or stabilized in response to somatropin therapy?	Y N

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

Prescriber (Or Authorized) Signature and Date