



Prior Authorization Form

**Arkansas Blue Cross and Blue Shield (Medicare)
Medi-Pak Rx (PDP) and Medi-Pak Advantage (PFFS)
Serostim (Medicare Determination)**

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 800-294-5979 with questions regarding the prior authorization process.
When conditions are met, we will authorize the coverage of Serostim (Medicare Determination).

Drug Name (select from list of drugs shown)

Serostim (somatropin)

Patient Information

Patient

Name: _____

Patient ID: _____

Patient

Group No.: _____

Patient

DOB: _____

Prescribing Physician

Physician

Name: _____

Physician

Phone: _____

Physician

Fax: _____

Physician

Address: _____

City, State,

Zip: _____

Diagnosis: _____

ICD

Code: _____

Please circle the appropriate answer for each applicable question.

- | | | |
|--|---|---|
| 1. Is the physician purchasing and providing the drug "incident to" physician services? | Y | N |
| 2. Does the patient have a diagnosis of cachexia or wasting syndrome associated with human immunodeficiency virus (HIV) infection?
[If the answer to this question is no, then no further questions.] | Y | N |
| 3. Has the patient had progressive weight loss greater than or equal to 10% of body weight?
[If the answer to this question is yes, then may skip to question 5.] | Y | N |
| 4. Does the patient have a Body Mass Index (BMI) less than 18.5?
[If the answer to this question is no, then no further questions.] | Y | N |
| 5. Has the patient been evaluated for other causes of weight loss such as inadequate nutritional intake, malabsorption, opportunistic infections, or hypogonadism?
[If the answer to this question is no, then no further questions.] | Y | N |
| 6. Will the patient continue to use their prescribed HIV (anti-viral) therapy?
[If the answer to this question is no, then no further questions.] | Y | N |



Arkansas BlueCross BlueShield

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7. Has the patient received a total of 12 weeks of Serostim therapy? Y N
 [If the answer to this question is yes, then no further questions.]
8. How many weeks of Serostim therapy has the patient received? _____
9. Does the patient have an active neoplasia (newly diagnosed or recurrent)? Y N
 [If the answer to this question is yes, then no further questions.]
10. Does the patient have an acute critical illness? Y N

Comments: _____

I affirm that the information given on this form is true and accurate as of this date.

Prescriber (Or Authorized) Signature and Date