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Magellan Rx MANAGEMENT

NYRx the Medicaid Pharmacy Program

Serostim® Prior Authorization Worksheet

Fax Number: 1-800-268-2990

Processing may be delayed if information submitted is illegible or incomplete. If your fax includes the standardized fax form, only the **Enrollee Name**, **Date of Birth**, **Medicaid ID**, and **Clinical Criteria** need to be completed and faxed as an attachment to process your request.

ENROLLEE INFORMATION

Enrollee's Last Name: _____ **Enrollee's First Name:** _____

Date of Birth: _____ **Enrollee's Medicaid ID (2 letters, 5 numbers, 1 letter):** _____

Enrollee's Street Address: _____

City: _____ **State:** _____ **Zip Code:** _____

PRESCRIBER INFORMATION

Prescriber's Last Name: _____ **Prescriber's First Name:** _____

National Provider Identifier (NPI) Number: _____ **Board Certified Specialty:** _____

Prescriber's Street Address: _____

City: _____ **State:** _____ **Zip Code** _____

Prescriber's Phone Number: _____ **Prescriber's Fax Number:** _____

REQUESTED DRUG INFORMATION

Drug Name: _____ **Drug Strength:** _____

Quantity: _____

Directions: _____

New Prescription: ☐ Yes ☐ No If **NO**, date therapy was initiated: _____

Enrollee's Last Name: **Enrollee's First Name:**

CLINICAL CRITERIA

1. Has the patient been diagnosed with human immunodeficiency virus infection and acquired immune deficiency syndrome (HIV/AIDS)-associated wasting, cachexia? **Please fax documentation.**

   ☐ Yes ☐ No

2. Has the patient had unintentional weight loss of 5% or greater from baseline pre-morbid weight or does the patient weigh an amount that indicates a recent significant weight loss has occurred (Body mass index (BMI) < 20 kg/m^2) in the absence of opportunistic infection?

   ☐ Yes ☐ No

3. Is patient on current anti-viral therapy?

   ☐ Yes ☐ No

   If **YES**, provide the anti-viral therapy that the patient is currently using:

4. Does patient have recent blood work to confirm an amylase level ≤ 3 times the upper normal limit, a creatinine level ≤ 2 mg/dL, OR a fasting triglyceride level ≤ 500 mg/dL? **Please fax in documentation.**

   ☐ Yes ☐ No

5. Does the patient have an active malignancy (other than Kaposi's sarcoma) or are they undergoing systemic chemotherapy, or being treated with interferon, anabolic steroids, or investigational drugs?

   ☐ Yes ☐ No

   If **YES**, provide clinical rationale for the use of Serostim® in this patient:

6. Does the patient have evidence of gastrointestinal (GI) bleeding, intestinal obstruction, malabsorption syndrome, or severe liver dysfunction?

   ☐ Yes ☐ No

   If **YES**, provide clinical rationale for the use of Serostim® in this patient:

7. Does the patient have angina pectoris, coronary artery disease, congestive heart failure, renal failure, or serious chronic edema?

   ☐ Yes ☐ No

   If **YES**, provide clinical rationale for the use of Serostim® in this patient:

Enrollee's Last Name: **Enrollee's First Name:**

CLINICAL CRITERIA *(CONTINUED)*

8. Does the patient have a history of glucose intolerance or uncontrolled hypertension?

   ☐ Yes ☐ No

   If **YES**, provide clinical rationale for the use of Serostim® in this patient:

9. Have other treatment modalities been tried and failed?

   ☐ Yes ☐ No

   If **YES**, provide the names of the treatments tried and failed below:

10. For **RENEWAL REQUESTS ONLY**, has the patient experienced a positive response to Serostim® therapy?

    ☐ Yes ☐ No

Prescriber Signature (Required) **Date**

I attest that Serostim® is medically necessary for this patient and that all the information on this form is accurate to the best of my knowledge.

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Prior Authorization Call Line: 1-877-309-9493

Billing Questions: 1-800-343-9000

For clinical questions or Clinical Drug Review Program questions, please visit http://newyork.fhsc.com or call 1-877-309-9493.