**Note**: 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:**

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

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**Address:**

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**City: State: Zip Code:**

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# PRESCRIBER INFORMATION

**Prescriber’s Last Name: Prescriber’s First Name:**

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

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**Address:**

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**City: State: Zip Code:**

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**Office Phone Number: Office Fax Number:**

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**Enrollee’s Last Name: Enrollee’s First Name:**

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# CLINICAL CRITERIA – DRUG INFORMATION

**Drug Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Strength:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Directions:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Quantity:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**New Prescription:**  Yes  No

If **NO**, date therapy initiated: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# 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

1. 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/m2) in the absence of opportunistic infection?

Yes  No

1. Is patient on current anti-viral therapy?

Yes  No

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. 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

1. 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:

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*(Form continued on next page.)*

1. 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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have other treatment modalities been tried and failed?

Yes  No

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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 of the information on this form is accurate to the best of my knowledge.* | | |

**Fax Number:** 1-800-268-2990

**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