**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:

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

*(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:

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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