NEW YORK STATE MEDICAID PROGRAM
PRIOR AUTHORIZATION INSTRUCTIONS FOR PRESCRIBERS

CLINICAL DRUG REVIEW PROGRAM

Prior Authorization Call Line 1- 877- 309- 9493

PROGRAM INFORMATION

- Drugs included in the Clinical Drug Review Program require prior authorization.
- A list of CDRP drugs is available at www.nyhealth.gov and at http://newyork.fhsc.com.
- Under the CDRP, only the prescriber, not an authorized agent, must call the prior authorization call line to initiate a prior authorization.
- Fax requests are **NOT** permitted for the Clinical Drug Review Program.
- When calling the staffed clinical call center, a pharmacy technician or a pharmacist will ask for specific clinical information.

PRESCRIBER PROCEDURE

- To initiate the prior authorization process, the prescriber must call the prior authorization phone line at **1-877-309-9493** and select **Option "1"** for Prescriber.

- Select **Option "1"** again to obtain a prior authorization for a CDRP drug. Please be prepared to provide the following information when calling:

  - Prescriber's Medicaid ID number or license number
  - Recipient's Medicaid ID number
  - CDRP drug name

- Each CDRP drug has specific clinical information that must be provided before a prior authorization will be issued. The clinical criteria relevant to each specific CDRP drug are listed at the end of the prior authorization worksheet.

- If uncertain which selection to make or if assistance with the prior authorization process is required, select **Option "3"** for assistance.

- Once authorization is given and a prior authorization number is obtained, the number must be written on the face of the prescription. Please be sure to include the "W" when writing the prior authorization number on the patient's prescription.

For billing questions, call 1-800-343-9000
For clinical concerns or Clinical Drug Review Program questions, visit www.nyhealth.gov and http://newyork.fhsc.com or call 1-877-309-9493
For Medicaid pharmacy policy and operations questions, call (518) 486-3209

NEW YORK STATE MEDICAID PROGRAM
PRIOR AUTHORIZATION WORKSHEET FOR PRESCRIBERS

CLINICAL DRUG REVIEW PROGRAM

Prior Authorization Call Line 1- 877- 309-9493

<table>
<tr><th colspan="4">RECIPIENT INFORMATION</th></tr>
<tr><td>Recipient Name:</td><td colspan="3">Street:</td></tr>
<tr><td>Recipient Medicaid ID#:
(2 letters, 5 numbers, 1 letter)</td><td>City:</td><td>State:</td><td>Zip:</td></tr>
<tr><th colspan="4">PRESCRIBER INFORMATION</th></tr>
<tr><td>Prescriber Name:</td><td colspan="3">Contact Person:</td></tr>
<tr><td rowspan="3">Prescriber ID Number (MMIS) __ __ __ __ __ __ __ __
OR License
NYS Physician /PA/Resident: 0 0 __ __ __ __ __ __
NYS Optometrist: U __ __ __ __ __ __ or V __ __ __ __ __ __
NYS Nurse Practitioner/Midwife: F __ __ __ __ __
NYS Dentist: 0 0 0 __ __ __ __ __
NYS Podiatrist: 0 0 0 0 __ __ __ __
OR
Out-of-State License: __ __ __ __ __ __ __ __
(Use your state abbreviation in the first two spaces.)</td><td colspan="3">Street:</td></tr>
<tr><td>City:</td><td>State:</td><td>Zip:</td></tr>
<tr><td>Office Phone#:</td><td colspan="2">Office Fax #:</td></tr>
<tr><th colspan="4">DIAGNOSIS AND MEDICAL INFORMATION</th></tr>
<tr><td>Drug Name:</td><td>Strength and Route of Administration:</td><td colspan="2">Frequency:</td></tr>
<tr><td>☐ New Prescription OR
Date Therapy Initiated:</td><td>Expected Length of Therapy:</td><td colspan="2">Qty:</td></tr>
<tr><td>Height/Weight:</td><td>Drug Allergies:</td><td colspan="2">Diagnosis:</td></tr>
<tr><td colspan="3">Prescriber's Signature:</td><td>Date:</td></tr>
<tr><th colspan="4">CLINICAL CRITERIA SPECIFIC TO A CDRP DRUG MUST BE COMPLETED
FOR PRIOR AUTHORIZATION</th></tr>
<tr><td colspan="4">Clinical criteria relevant to each specific CDRP drug is available on the proceeding pages, and must be completed before prior authorization will be given.</td></tr>
<tr><th colspan="4">PRIOR AUTHORIZATION NUMBER</th></tr>
<tr><td colspan="4">Prior Authorization Number (11 digits): __ __ __ __ __ __ __ __ __ __ __</td></tr>
</table>

The attached mandatory Clinical Criteria must be completed
before a prior authorization will be issued.

DO NOT FAX THIS FORM

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Revised 9/06

NEW YORK STATE MEDICAID PROGRAM
PRIOR AUTHORIZATION WORKSHEET FOR PRESCRIBERS

CLINICAL DRUG REVIEW PROGRAM

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CLINICAL CRITERIA

SEROSTIM:

Dose (based on weight, see chart below)	_____ mg SC daily
Day supply (maximum 28 days)	_____
Does patient have clearly documented HIV infection or AIDS?	
Is patient 18 years of age or older?	
Is patient receiving at least 100% of estimated caloric requirement on current nutritional regimen?	
Are you or have you consulted with an HIV specialist?	
Does patient have unintentional weight loss of at least 5% or greater from baseline pre-morbid weight or weigh an amount that indicates a recent significant weight loss has occurred (BMI<20kg/m2) in the absence of opportunistic infection?	
Is patient on current anti-viral therapy with good viral suppression?	
Does the patient have recent blood work to confirm an amylase level ≤ 3 times the upper normal limit, a creatinine level ≤ 2mg/dl or a fasting triglyceride level ≤ 500mg/dl?	
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?	
Does the patient have evidence of GI bleeding, intestinal obstruction, malabsorption syndrome, or severe liver dysfunction?	
Does the patient have angina pectoris, coronary artery disease, congestive heart failure, renal failure, or serious chronic edema?	
Does the patient have a history of glucose intolerance or uncontrolled hypertension?	
Have other treatment modalities been tried and failed?	
Patient's current weight in pounds	_____lbs
Patient's height in inches	_____inches
Patient's current Body Mass Index (BMI)	_____

SEROSTIM DOSING CHART:

WEIGHT RANGE	APPROPRIATE DOSE
> Over 121 pounds (>55 kilograms)	6 mg SC daily
99 to 121 pounds (45-55 kilograms)	5 mg SC daily
77 to 98 pounds (35-44 kilograms)	4 mg SC daily

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