Pharmacy Prior Authorization

AETNA BETTER HEALTH NEW JERSEY (MEDICAID)

Serostim (Medicaid)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health New Jersey at **1-855-296-0323**.
When conditions are met, we will authorize the coverage of Serostim (Medicaid).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name *(circle drug)*

Serostim (somatropin)

Other, specify drug _____

Quantity _____ Frequency _____ Strength _____

Route of administration _____ Expected length of therapy _____

Patient information

Patient name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient phone: _____

Prescribing physician

Physician name: _____

Specialty: _____ NPI number: _____

Physician fax: _____ Physician phone: _____

Physician address: _____ City, state, zip: _____

Diagnosis: _____ **ICD Code:** _____

Circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this member (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 5.] Y N

2. Is the member responding to therapy with Serostim as demonstrated by a body mass index (BMI) that has improved or stabilized? Y N

   Please provide current height and weight: _____ Y N

   [If no, then no further questions.] Y N

3. Is the member on antiretroviral therapy? Y N

[If no, then no further questions.] Y N

4. Has the member received therapy with Serostim for greater than or equal to 48 weeks? Y N

   [No further questions.] Y N

5. Does the member have a diagnosis of human immunodeficiency virus (HIV)-associated cachexia or wasting? Y N

   [If no, then no further questions.] Y N

6. Is the member on antiretroviral therapy? Y N

   [If no, then no further questions.] Y N

7. Has the member had an inadequate response, intolerable side effects or contraindication to megestrol acetate or dronabinol? Y N

   Please describe the medication tried and the reason for treatment failure: Y N

   _____

   [If no, then no further questions.] Y N

8. Is the request for a member who experienced unintentional weight loss of more than 10 percent over 12 months OR unintentional weight loss of more than 5 percent over 6 months OR has a body mass index (BMI) less than 20 kg/m2 prior to initiating therapy with Serostim OR weighs less than 90 percent of the lower limit of ideal body weight (IBW)? Y N

   Please provide baseline and current height, weight, and BMI: Y N

   _____

   [If no, then no further questions.] Y N

9. Has weight loss due to other causes (e.g., depression, mycobacterium avium complex (MAC), chronic infectious diarrhea, or malignancy with exception of Kaposi's sarcoma limited to skin or mucous membranes) been ruled out? Y N

   [If no, then no further questions.] Y N

10. Is therapy being prescribed by or in consultation with an infectious disease or human immunodeficiency virus (HIV) specialist? Y N

    [If no, then no further questions.] Y N

11. Has the member received therapy with Serostim for greater than or equal to 48 weeks? Y N

Comments:

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

Prescriber (Or Authorized) Signature **Date**