PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Serostim® (somatropin (rDNA origin) for injection)

Phone: 215-991-4300 Fax back to: 866-240-3712

HEALTH PARTNERS manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please print clearly.**

Patient Name:	**Physician Name:**	
Member Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic. Id:
Address:	Address:	
City, State, Zip:	City, State, Zip:	

Drug Name: Expedited/Urgent

Directions:

Please answer the following questions and sign below:
Q1. What is the duration of the therapy requested? 1 month or less More than 1 month
Q2. Does the member have a diagnosis of HIV/AIDS? Yes No
Q3. Does the member have a secondary diagnosis of Wasting Syndrome as defined by the CDC? (weight loss of at least 10% in the presence of diarrhea or chronic weakness, and opportunistic infections ruled out) Yes No
Q4. Have you attached a nutritional consult and results of BIA? Yes No
Q5. Does the member have a documented BCM less than 100%? Yes No
Q6. Is the member male or female? Male Female
Q7. If the member is male, does he have normal testosterone level greater than 500ng/dl? Yes No
Q8. Is the member currently taking anti-viral therapy? Yes No
Q9. Does the patient have a contraindication to or treatment failure with Oxandrin? Yes No
Q10. Deliver to: Physician's Office Home Delivery
Q11. Delivery date needed:

Physician Signature **Date**

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