

**Physician SEROSTIM® Prior Authorization Request Form**

Fax to AmeriHealth Mercy Pharmacy Services at **888-981-5202**, or to speak to a representative call **866-610-2774**. *Form must be completed for processing.*



Patient Name: \_\_\_\_\_

AmeriHealth Mercy ID#: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Phone #: \_\_\_\_\_

Birth date: \_\_\_\_\_

Physician Name: \_\_\_\_\_

License #: \_\_\_\_\_

Address: \_\_\_\_\_

Apt # or Suite #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Zip Code: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Phone #: \_\_\_\_\_

Fax #: \_\_\_\_\_

Physician Signature \_\_\_\_\_

Deliver to:  
 Physician's Office     Patient's Home     Patient filling at local Pharmacy (Name) \_\_\_\_\_ Fax: \_\_\_\_\_

To be Administered from: \_\_\_\_\_ to \_\_\_\_\_ or on: \_\_\_\_\_

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

Diagnosis: \_\_\_\_\_

Sig (How Administered): \_\_\_\_\_

ICD-9 Diagnosis Code: \_\_\_\_\_

Provide documentation (Attach BIA analysis report) of Body Impedance Analysis (BIA) including Body Cell mass and BMI.

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lb \_\_\_\_\_ kg

1. Does the member currently have HIV/AIDS? (please circle) YES NO  
If YES, please attach documentation from an infectious disease doctor indicating that the member is receiving optimal antiviral therapy or recent (within the past 2 months) laboratory documentation indicating plasma HIV RNA of less than 50 copies/ml:
2. Does the member currently have cancer (excluding Kaposi's sarcoma)? (please circle) YES NO  
If YES, please explain \_\_\_\_\_
3. Does the member currently have any symptomatic, opportunistic infections causing GI distress (e.g. diarrhea, NV, etc.)? (please circle) YES NO  
If YES, please explain \_\_\_\_\_
4. Is the member currently receiving nutritional support to reach nutritional goals? (please circle) YES NO  
If YES, please explain (e.g. oral/liquid supplement, provided meal assistance, etc.) \_\_\_\_\_
5. Does the member currently have any psychiatric disorders (e.g. anxiety, depression, etc)? (please circle) YES NO  
If YES, please document treatment \_\_\_\_\_
6. Is the member currently receiving an anabolic medication (Oxandrin, Winstrol, Nandrolone) AND an appetite stimulant (Marinol or Megace)? (please circle) YES NO  
If NO, please explain (e.g. Is there a medical reason for not taking both these medications?) \_\_\_\_\_
7. For males, is the member currently receiving testosterone replacement therapy? (please circle) YES NO  
If NO, please attach current documentation (lab result within the past 2 months) of normal testosterone blood levels.