Serostim (for Maryland only)
Prior Authorization Request

Send completed form to: Case Review Unit, CVS Caremark Prior Authorization Fax: 1-866-249-6155

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-866-249-6155**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-866-814-5506.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient's Name: _____ **Date**: _____
Patient's ID: _____ **Patient's Date of Birth:** _____
Physician's Name: _____
Specialty: _____ **NPI#:** _____
Physician Office Telephone: _____ **Physician Office Fax:** _____
Request Initiated For: _____

1. What is the diagnosis? ❑ HIV-associated wasting/cachexia ❑ Other _____
2. What is the ICD-10 code? _____
3. Would the prescriber like to request an override of the step therapy requirement? ❑ Yes ❑ No *If No, skip to #6*
4. Has the member received the medication through a pharmacy or medical benefit within the past 180 days? ❑ Yes ❑ No ***ACTION REQUIRED: Please provide documentation to substantiate the member had a prescription paid for within the past 180 days (i.e. PBM medication history, pharmacy receipt, EOB etc.)***
5. Is the medication effective in treating the member's condition? ❑ Yes ❑ No *Continue to #6 and complete this form in its entirety.*
6. Is Serostim prescribed by, or in consultation with, an infectious disease specialist? ❑ Yes ❑ No
7. Is the patient on anti-retroviral therapy? ❑ Yes ❑ No
8. Does the patient have active malignancy or history of malignancy in the past 12 months? ❑ Yes ❑ No
9. Is the patient currently receiving treatment with Serostim through insurance (excludes obtainment as samples or via manufacturer's patient assistance programs)? ❑ Yes ❑ No *If No, skip to #12*
10. Did the patient's BMI increase or stabilize in response to Serostim therapy? ❑ Yes ❑ No
11. What is the patient's current BMI? _____ kg/m^2 *No further questions*

12. Has the patient tried and had a suboptimal response to alternative therapies?
If Yes, indicate all that apply and skip to #11 or mark "None of the above."
❑ Dronabinol ❑ Testosterone therapy if hypogonadal ❑ Megestrol ❑ Cyproheptadine
❑ Other _____ ❑ None of the above

13. Did the patient have a contraindication or intolerance to alternative therapies? ❑ Yes ❑ No

14. Prior to initiating therapy with Serostim, what was the patient's body mass index (BMI)? _____ kg/m^2

15. Prior to initiating therapy with Serostim, did the patient experience unintentional weight loss greater than 5% of body weight in the previous 6 months? ❑ Yes ❑ No

16. Has the patient received treatment with Serostim? ❑ Yes ❑ No

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**