

**Serostim
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.

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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. Is Serostim prescribed by, or in consultation with, an infectious disease specialist? Yes No
4. Is the patient on anti-retroviral therapy? Yes No
5. Does the patient have active malignancy or history of malignancy in the past 12 months? Yes No
6. 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 #9*
7. Did the patient's BMI increase or stabilize in response to Serostim therapy? Yes No
8. What is the patient's current BMI? _____ kg/m² *No further questions*
9. 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
10. Did the patient have a contraindication or intolerance to alternative therapies? Yes No
11. Prior to initiating therapy with Serostim, what was the patient's body mass index (BMI)? _____ kg/m²
12. 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
13. Has the patient received treatment with Serostim? Yes No

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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)