CLEAR
HEALTH ALLIANCE

Prior Authorization
Growth Hormone for HIV Wasting in Adults
Serostim®

Initial approval period is for a total of ninety (90) days; 30 days for retreatment.

Beneficiary's Medicaid ID#

Date of Birth (MM/DD/YYYY) / /

Beneficiary's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, RN)

Prescriber Phone Number -

Prescriber Fax Number -

Official medical documentation must be provided to support the information indicated below, in addition to a copy of the original prescription and a six-month weight chronical indicating the most recent weights.

1. Diagnosis: ☐ Initiation of therapy ☐ Retreatment (if retreatment, complete #10 also)
2. Is recipient currently on HAART Regimen (if so, list):
   1) 2) 3) 4)
3. Weight 6 months prior/date: lb(s)/ ; Weight 3 months prior/date: lb(s)/date
4. Current BMI/date: / Current weight/date: lb(s)/ height: (ft. and in)
5. Has the recipient received a nutritional assessment to assure adequate caloric intake (anorexia), to rule out malabsorption, and psychosocial factors that may influence food intake? ☐ Yes ☐ No
6. If the recipient has inadequate caloric intake and anorexia has there been a trial of an appetite stimulant? ☐ Yes ☐ No
   If yes, indicate dosage and date:
   Drug/directions ; Dates: to
7. Has it been confirmed that there are no active neoplasia? ☐ Yes ☐ No
8. Is the recipient hypogonadal? ☐ Yes ☐ No
   If yes, is or has testosterone replacement therapy being administered? ☐ Yes ☐ No
9. Has the recipient failed a minimum of a 4 week trial of an anabolic steroid (eg. oxandrolone)? ☐ Yes ☐ No
   Document dosage and dates of anabolic steroid use: Drug/directions ;
   Dates: to
   If no trial of anabolic steroids, provide rationale:
10. Is the Serostim dosing within the recommended guidelines for weight? ☐ Yes ☐ No
11. Previous Treatment Results if a request for retreatment?
    Start date: Body Weight: lb(s) BMI:
    End date: Body Weight: lb(s) BMI:

Prescriber's Signature: DATE:

The provider must retain copies of all documentation for five years.

Fax Information to:
Clear Health Alliance
Tel: (877) 577-9044
Fax: (877) 577-9045

For CLEAR HEALTH PHARMACY Use Only

DATE: NOTIFIED:
APPROVED: START DATE: EXPIRATION DATE:
DENIAL OVERRIDE: REASON: