FLORIDA MEDICAID

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.

Note: Form must be completed in full. An incomplete form may be returned.

Recipient's Medicaid ID#

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

Recipient's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, ARNP, PA)

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 (e.g., 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:

REQUIRED FOR REVIEW: Copies of medical records (i.e. diagnostic evaluations and recent chart notes), the original prescription, and the most recent copies of related labs

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

Fax Information to:

PERFORMRx℠

Pharmacy Provider Services
Fax: 855-825-2717
Phone: 1-800-617-5727

Serostim® Criteria:

1. The physician must first complete, sign, and date the Serostim PA form.
2. For initial therapy, or request for additional therapy, the physician must submit official medical records to support or answer all the questions addressed on the PA form, in addition to a six-month weight chronical indicating the most recent weights.
3. Recipient must 18 years of age or older.
4. Recipient must have a diagnosis of HIV associated wasting or cachexia.
5. Recipient must be on anti-retroviral therapy.
6. Recipient must have experienced at least a 7.5% unintentional weight loss within the last 6 months, 10% involuntary weight loss in last 12 months, or have a Body Mass Index (BMI) < 20 for initial approval.
7. Alternatively, recipient may have a Body Cell Mass (BCM) < 35% (male) or <23% (female) of total body weight and a Body Mass Index less than 27. Another qualifier would be a greater than or equal to 5% BCM loss over 6 months. **(ATTACH A SERIES OF BIOELECTRIC IMPEDANCE ANALYSIS [BIA] RESULTS IF APPLICABLE.)**
8. Treatment must also include nutritional assessment and counseling. Total parenteral nutrition is sometimes of benefit in patients with damaged gastrointestinal tracts. Appetite stimulants such as megesterol may promote weight gain; however, most gain with megestrol acetate is in fat rather than BCM.
9. Serostim is contraindicated in patient's with active neoplasia.
10. Testosterone replacement therapy (minimum of 4 weeks) in hypogonadal men may increase lean body mass and muscle strength.
11. Oxandrolone has been found to produce significant increases in weight gain and BCM.
12. Dosage must be adjusted according to recipient's weight.

Weight Range	Dose
>55kg (121 lb)	6 mg SC daily
45-55kg (99-121 lb)	5 mg SC daily
35-45kg (75-99 lb)	4 mg SC daily
<35 kg(<75 lb)	0.1 mg/kg SC daily

13. Length of therapy is 12 weeks; however, if a positive response to therapy (a 2% or greater increase in body weight and/or BCM) occurs but wasting is still evident, treatment may be continued and response reevaluated on a month-by-month basis. **THEREFORE, RETREATMENT WILL BE APPROVED FOR A MAXIMUM OF 30 DAYS AT A TIME.**
14. Physician must submit a new PA form for additional therapy.