01/19/2016

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS MEDICAID

Serostim (IL88)

This fax machine is located in a secure location as required by HIPAA regulations.
Complete/review information, sign and date. Fax signed forms to Aetna Better Health Illinois Medicaid at **1-855-684-5250**.
Please contact Aetna Better Health Illinois Medicaid at **1-866-212-2851** with questions regarding the Prior Authorization process.
When conditions are met, we will authorize the coverage of Serostim (IL88).
Please note that all authorization requests will be reviewed as the AB rated generic (when available) unless states otherwise.

Drug Name (select from list of drugs shown)

Serostim (somatropin) Other, Please specify

Quantity _____ Frequency _____ Strength _____

Route of Administration _____ Expected Length of therapy _____

Patient Information

Patient Name: _____

Patient ID: _____

Patient Group No.: _____

Patient DOB: _____

Patient Phone: _____

Prescribing Physician

Physician Name: _____

Specialty: _____ NPI Number: _____

Physician Fax: _____ Physician Phone: _____

Physician Address: _____ City, State, Zip: _____

Diagnosis: _____ ICD Code: _____

Please circle the appropriate answer for each question.

1. Has this plan authorized this medication in the past for this patient (i.e., previous authorization is on file under this plan)? Y N

   [If no, skip to question 3.]

2. Is the patient responding to therapy with Serostim (i.e., increased weight gain, improved physical endurance, better appetite)? Please provide brief details of symptom improvement: Y N

   _____

   [If no, no further questions.]

   [If yes, skip to question 7.]

3. Does the patient have a diagnosis of adult HIV wasting/cachexia? Y N

   [If no, no further questions.]

4. Is the patient on antiretroviral therapy? Y N

   [If no, no further questions.]

5. Has the patient tried and failed megestrol? Please describe reason for treatment failure: Y N

   _____

   [If no, then no further questions.]

6. Has the patient experienced progressive weight loss of more than 10% of their pre-HIV baseline weight OR has a body mass index (BMI) less than 20 kg/m2 that cannot be explained by a concurrent illness other than HIV infection? Please provide baseline and current height, weight, and BMI: Y N

   _____

   [If no, then no further questions.]

7. Has the patient received therapy with Serostim for greater than or equal to 48 weeks? Y N

Comments:

_____

_____

I affirm that the information given on this form is true and accurate as of this date.

_____

Prescriber (Or Authorized) Signature Date