01/19/2016

Prior Authorization

AETNA BETTER HEALTH OF ILLINOIS FAMILY HEALTH PLAN (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 **1-844-242-0908**.
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:

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

____

Prescriber (Or Authorized) Signature **Date**