PRIOR AUTHORIZATION REQUEST FORM

EOC ID:

Serostim

Phone: 800-728-7947 Fax back to: 866-880-4532

The Scott & White Health Plan Pharmacy Department manages the pharmacy drug benefit for your patient. Certain requests for coverage require review with the prescribing physician. Please answer the following questions and fax this form to the number listed above. **Please note any information left blank or illegible may delay the review process.**

Patient Name:	**Prescriber Name:** **Supervising Physician:**	
Member/Subscriber Number:	Fax:	Phone:
Date of Birth:	Office Contact:	
Group Number:	NPI:	State Lic ID:
Address:	Address:	
City, State ZIP:	City, State ZIP:	
Primary Phone:	Specialty/facility name (if applicable):	

Drug Name and Strength:

Directions / SIG:

Please attach any pertinent medical history or information for this patient that may support approval. Please answer the following questions and sign.

Q1. What diagnosis is this drug being prescribed for (pick one)?

- ☐ HIV infection with wasting or cachexia
- ☐ Other

Q2. Please provide ICD code(s) for diagnosis.

Q3. Please indicate location of administration.

- ☐ Home
- ☐ Long Term Care (LTC) facility
- ☐ Physician office (drug from office stock- buy and bill)
- ☐ Physician office (drug from pharmacy with a prescription)

Q4. Specify the prescriber's specialty.

- ☐ Endocrinology
- ☐ Other (please specify)

Q5. Has the patient had a documented unintentional weight loss of greater than 10% from baseline?

☐ Yes ☐ No

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PART OF BAYLOR SCOTT & WHITE HEALTH

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Q6. Does the patient weigh less than 90% of the lower limit of ideal body weight?

☐ Yes ☐ No

Q7. Does the patient have a body mass index (BMI) of less than 20 kg/m2?

☐ Yes ☐ No

Q8. Can the patient consume or be fed through parenteral or enteral feeding greater than 75% of maintenance energy requirements based on current body weight?

☐ Yes ☐ No

Q9. Is the patient on antiretroviral therapy for greater than 30 days prior to beginning therapy and will the patient continue antiretroviral therapy throughout treatment?

☐ Yes ☐ No

Q10. Will the therapy be limited to 12 weeks?

☐ Yes ☐ No

Q11. Additional Comments

Prescriber Signature

Date

□ Expedited/Urgent - By checking this box and signing above, I certify that applying the standard review timeframe may seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function

Lack of the necessary documentation may result in a medical necessity denial. Requesting providers may speak to the SWHP medical director at 1-888-316-7947 regarding the case to have an opportunity to help impact the decision on a request before coverage has been decided.

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