Physician SEROSTIM® Prior Authorization Request Form

Fax to Keystone Mercy Pharmacy Services at 215-937-5018, or to speak to a representative call **800-588-6767**. *Form must be completed for processing*.

KEYSTONE MERCY HEALTH PLAN
A Program of Keystone First and Mercy Health Plan

Patient Name: _____ Keystone Mercy ID#: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Phone #: _____ Birth date: _____

Physician Name: _____ License #: _____

Address: _____ Apt # or Suite #: _____

City: _____ State: _____ Zip Code: _____

Contact Person: _____ Phone #: _____ Fax #: _____

Physician Signature _____

Deliver to:
☐ Physician's Office ☐ Patient's Home ☐ Patient filling at local Pharmacy (Name) _____ Fax: _____

To be Administered from: _____ to _____ or on: _____

Drug Name: _____ Diagnosis: _____

Sig (How Administered): _____ ICD-9 Diagnosis Code: _____

Provide documentation (Attach BIA analysis report) of Body Impedance Analysis (BIA) including Body Cell mass and BMI.
Height: _____ Weight: _____lb _____kg

1. Does the member currently have HIV/AIDS? (please circle) YES NO
   If YES, please attach documentation from an infectious disease doctor indicating that the member is receiving optimal antiviral therapy or recent (within the past 2 months) laboratory documentation indicating plasma HIV RNA of less than 50 copies/ml:

2. Does the member currently have cancer (excluding Karposi's sarcoma)? (please circle) YES NO
   If YES, please explain _____
   _____

3. Does the member currently have any symptomatic, opportunistic infections causing GI distress (e.g. diarrhea, N/V, etc.)? (please circle) YES NO
   If YES, please explain _____
   _____

4. Is the member currently receiving nutritional support to reach nutritional goals? (please circle) YES NO
   If YES, please explain (e.g. oral/liquid supplement, provided meal assistance, etc.) _____
   _____

5. Does the member currently have any psychiatric disorders (e.g. anxiety, depression, etc)? (please circle) YES NO
   If YES, please document treatment _____
   _____

6. Is the member currently receiving an anabolic medication (Oxandrin, Winstrol, Nandrolone) AND an appetite stimulant (Marinol or Megace)? (please circle) YES NO
   If NO, please explain (e.g. Is there a medical reason for not taking both these medications?) _____
   _____

7. For males, is the member currently receiving testosterone replacement therapy? (please circle) YES NO
   If NO, please attach current documentation (lab result within the past 2 months) of normal testosterone blood levels.