PA Request Criteria

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This fax machine is located in a secure location as required by HIPAA regulations. Fax complete signed and dated forms to CVS/Caremark at . Please contact CVS/Caremark at 1-888-413-2723 with questions regarding the prior authorization process. When conditions are met, we will authorize the coverage of the medication.

**Patient Name:** _____ **Date:** 5/13/2025
**Patient ID:** _____ **Patient Date Of Birth:** _____
**Patient Group No:** **Patient Phone:** **Physician Name:**
_____ **NPI#:** _____ **Specialty:**
_____ **Physician Office Telephone:**
**Physician Office Address:** _____
_
**Drug Name (specify drug)** _____
**Quantity:** _____ **Frequency:** _____ **Strength:** _____
**Route of Administration:** _____ **Expected Length of Therapy:** _____
**Diagnosis:** _____ **ICD Code:** _____
**Comments:** _____
_____
_____

**Please check the appropriate answer for each applicable question.**

1. What is the diagnosis?
   - Human immunodeficiency virus (HIV)-associated wasting/cachexia (If checked, go to 2) ☐
   - Other, please specify. (If checked, no further questions) ☐
   _____
2. Is the patient currently receiving antiretroviral therapy? **Y** ☐ **N** ☐
3. Is the request for continuation of therapy? **Y** ☐ **N** ☐
4. Is the patient currently receiving Serostim through samples or a manufacturer's patient assistance program?
   - Yes (If checked, go to 5) ☐
   - No (If checked, go to 8) ☐
   - Unknown (If checked, go to 5) ☐
5. Has the patient tried and had a suboptimal response to alternative therapies (e.g., dronabinol [Marinol], megestrol acetate [Megace], cyproheptadine, or testosterone if hypogonadal)? **Y** ☐ **N** ☐
6. Does the patient have a contraindication or intolerance to alternative therapies? **Y** ☐ **N** ☐
7. What is the patient's PRETREATMENT (before initiating therapy with Serostim) body mass index (BMI)? (Note: m2 represents meters squared.)
   - Less than 18.5 kg/m2 (If checked, no further questions) ☐
   - Greater than or equal to 18.5 kg/m2 (If checked, no further questions) ☐
8. What is the patient's current body mass index (BMI)? (Note: m2 represents meters squared.)
   - Less than 27 kg/m2 (If checked, no further questions) ☐
   - Greater than or equal to 27 kg/m2 (If checked, no further questions) ☐

I attest that the medication requested is medically necessary for this patient. I further attest that the information provided is accurate and true, and that the documentation supporting this information is available for review if requested by the claims processor, the health plan sponsor, or, if applicable a state or federal regulatory agency.

_____

**Prescriber (Or Authorized) Signature and Date**

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