AvMed

PHARMACY PRIOR AUTHORIZATION/STEP-EDIT REQUEST*

Directions: **The prescribing physician must sign and clearly print name (preprinted stamps not valid) on this request**. All other information may be filled in by office staff; **fax to 1-305-671-0200**. No additional phone calls will be necessary if all information (including phone and fax #s) on this form is correct. **If the information provided is not complete, correct, or legible, the authorization process can be delayed.**

Drug Requested: Serostim® (somatropin [rDNA origin])

MEMBER & PRESCRIBER INFORMATION: Authorization may be delayed if incomplete.

Member Name: _____

Member AvMed #: _____ **Date of Birth:** _____

Prescriber Name: _____

Prescriber Signature: _____ **Date:** _____

Office Contact Name: _____

Phone Number: _____ **Fax Number:** _____

DEA OR NPI #: _____

DRUG INFORMATION: Authorization may be delayed if incomplete.

Drug Form/Strength: _____

Dosing Schedule: _____ **Length of Therapy**: _____

Diagnosis: _____ **ICD Code, if applicable:** _____

Weight: _____ **Date:** _____

Maximum Approved dose: 0.1 mg/kg once daily at bedtime (maximum: 6 mg/day);
Daily dose based on body weight:

Weight	Dosage
<35 kg	0.1 mg/kg
35 to 45 kg	4 mg
45 to 55 kg	5 mg
>55 kg:	6 mg

Medical notes MUST be submitted to support each line checked on this request.

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CLINICAL CRITERIA: Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

Initial Approval: 6 months

- ❑ Serostim® being prescribed by or in consultation with an infectious disease specialist

AND

- ❑ Member has diagnosis of AIDS related wasting/cachexia

AND

- ❑ Member has had involuntary weight loss of at least 10% of body weight

AND

- ❑ No concomitant illnesses are present that would contribute to weight loss.

AND

- ❑ Member have a body mass index (BMI) less than 27kg/m2

AND

- ❑ Patient has had a suboptimal response to **at least ONE (1)** of the following therapies for wasting or cachexia:
  - ❑ megestrol
  - ❑ dronabinol
  - ❑ cyproheptadine
  - ❑ testosterone therapy if hypogonadal

AND

- ❑ Serostim® will be used in combination with antiretroviral therapy

AND

- ❑ Member does not have an active malignancy

Reauthorization Approval: 12 months. Check below all that apply. All criteria must be met for approval. To support each line checked, all documentation, including lab results, diagnostics, and/or chart notes, must be provided or request may be denied.

- ❑ Member currently receiving therapy with Serostim used in combination with antiretroviral therapy

AND

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- ❑ Member demonstrated an improvement in symptoms in response to therapy with Serostim **(must submit chart note documentation of improvement while on therapy)**

AND

- ❑ Body mass index (BMI) has improved or stabilized **(must submit chart note documentation of current BMI)**

Medication being provided by a Specialty Pharmacy - PropriumRx

Not all drugs may be covered under every Plan

If a drug is non-formulary on a Plan, documentation of medical necessity will be required.

****Use of samples to initiate therapy does not meet step edit/ preauthorization criteria.****

****Previous therapies will be verified through pha rmacy paid claims or submitted chart notes.****

***Approved by Pharmacy and Therapeutics Committee:** 5/21/2020
REVISED/UPDATED: ~~8/31/2020;10/11/2021;~~ **10/30/2023**