



Prior Authorization  
Growth Hormone for HIV Wasting in Adults  
Serostim®

Initial approval period is for a total of ninety (90) days; 30 days for retreatment.

Beneficiary's Medicaid ID#

Date of Birth (MM/DD/YYYY)  /  /

Beneficiary's Full Name

Prescriber's Full Name

Prescriber License # (ME, OS, RN)

Prescriber Phone Number  -

Prescriber Fax Number  -

Official medical documentation must be provided to support the information indicated below, in addition to a copy of the original prescription and a six-month weight chronical indicating the most recent weights.

- Diagnosis:   Initiation of therapy  Retreatment (if retreatment, complete #10 also)
- Is recipient currently on HAART Regimen (if so, list):  
1)  2)  3)  4)
- Weight 6 months prior/date:  lb(s)/; Weight 3 months prior/date:  lb(s)/date
- Current BMI/date:  /  Current weight/date:  lb(s)/ height:  (ft and in)
- Has the recipient received a nutritional assessment to assure adequate caloric intake (anorexia), to rule out malabsorption, and psychosocial factors that may influence food intake?  Yes  No
- If the recipient has inadequate caloric intake and anorexia has there been a trial of an appetite stimulant?  Yes  No  
If yes, indicate dosage and date:  
Drug/directions ; Dates:  to
- Has it been confirmed that there are no active neoplasia?  Yes  No
- Is the recipient hypogonadal?  Yes  No  
If yes, is or has testosterone replacement therapy being administered?  Yes  No
- Has the recipient failed a minimum of a 4 week trial of an anabolic steroid (eg. oxandrolone)?  Yes  No  
Document dosage and dates of anabolic steroid use: Drug/directions ;  
Dates:  to   
If no trial of anabolic steroids, provide rationale:
- Is the Serostim dosing within the recommended guidelines for weight?  Yes  No
- Previous Treatment Results if a request for retreatment?  
Start date:  Body Weight:  lb(s) BMI:   
End date:  Body Weight:  lb(s) BMI:

Prescriber's Signature:  DATE:

**The provider must retain copies of all documentation for five years.**

Fax or mail completed forms to:  
Simply Healthcare Plans  
Health Services Department  
1701 Ponce de Leon Blvd., Suite 300  
Miami, FL 33134  
Fax: (877) 577-9045

For Information Only:  
Phone:  
(877) 577-9044

For SHP Use Only	
DATE: <input type="text"/>	NOTIFIED: <input type="text"/>
APPROVED: <input type="text"/>	START DATE: <input type="text"/> EXPIRATION DATE: <input type="text"/>
DENIED: <input type="text"/>	REASON: <input type="text"/>